

103D CONGRESS
2D SESSION

S. 2396

Entitled the "Affordable Health Care Now Act".

IN THE SENATE OF THE UNITED STATES

AUGUST 16 (legislative day, AUGUST 11), 1994

Mr. LOTT introduced the following bill; which was read the first time

A BILL

Entitled the "Affordable Health Care Now Act".

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

4 (a) SHORT TITLE.—This Act may be cited as the
5 "Affordable Health Care Now Act of 1994".

6 (b) TABLE OF CONTENTS OF TITLES AND SUB-
7 TITLES IN ACT.—The following are the titles and subtitles
8 contained in this Act:

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for Individuals and Their Families

Subtitle B—Reform of Health Insurance

Subtitle C—Preemption

Subtitle D—Health Deduction Fairness

Subtitle E—Improved Access to Community Health Services

Subtitle F—Improved Access to Rural Health Services
 Subtitle G—Assistance in Enrolling Uninsured Children in Health Insurance
 Subtitle H—Medicaid Reform
 Subtitle I—Remedies and Enforcement with Respect to Group Health Plans
 Subtitle J—Delivery of Health Care Services to Illegal Immigrants

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

Subtitle A—Medical Malpractice Liability Reform
 Subtitle B—Administrative Cost Savings and Fair Health Information Practices
 Subtitle C—Deduction for Cost of Catastrophic Health Plan; Medical Savings
 Accounts
 Subtitle D—Anti-Fraud
 Subtitle E—Increased Medicare Beneficiary Choice; Additional Medicare Re-
 forms
 Subtitle F—Health Care Antitrust Improvements
 Subtitle G—Encouraging Enforcement Activities of Medical Self-Regulatory En-
 tities
 Subtitle H—Reform of Clinical Laboratory Requirements for Simple Tests
 Subtitle I—Miscellaneous Provisions

TITLE III—LONG-TERM CARE

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 Subtitle B—Establishment of Federal Standards for Long-term Care Insurance
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5 PART 1—REQUIRED COVERAGE OPTIONS FOR EL- 6 IGIBLE EMPLOYEES, SPOUSES, AND DEPEND- 7 ENTS

8 SEC. 1001. REQUIRING EMPLOYERS TO OFFER OPTION OF 9 COVERAGE FOR ELIGIBLE INDIVIDUALS.

10 (a) IN GENERAL.—Each employer shall make avail-
11 able with respect to each eligible employee a group health
12 plan under which—

(1) coverage of each eligible individual with respect to such an eligible employee may be elected on an annual basis for each plan year,

(2) subject to subsection (d), coverage is provided for at least the required coverage specified in subsection (c), and

(3) each eligible employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

An employer is not required under this subsection to make any contribution to the cost of coverage under such a plan.

(b) SPECIAL RULES.—

(1) EXCLUSION OF NEW EMPLOYERS AND CERTAIN SMALL EMPLOYERS.—Subsection (a) shall not apply to any employer for any plan year if, as of the beginning of such plan year—

(A) such employer (including any predecessor thereof) has been an employer for less than 2 years,

(B) such employer has no more than 2 eligible full-time employees, or

(C) there are no more than 2 full-time eligible employees who both are not covered under any group health plan and do not have health insurance coverage.

1 (2) EXCLUSION OF FAMILY MEMBERS.—Under
2 such procedures as the Secretary may prescribe, any
3 relative of an employer may be, at the election of the
4 employer, excluded from consideration as an eligible
5 employee for purposes of applying the requirements
6 of subsection (a). In the case of an employer that is
7 not an individual, an employee who is a relative of
8 a key employee (as defined in section 416(i)(1) of
9 the Internal Revenue Code of 1986) of the employer
10 may, at the election of the key employee, be consid-
11 ered a relative excludable under this paragraph.

12 (3) OPTIONAL APPLICATION OF WAITING PE-
13 RIOD.—A group health plan shall not be treated as
14 failing to meet the requirements of subsection (a)
15 solely because a period of service by an eligible em-
16 ployee of not more than 60 days is required under
17 the plan for coverage under the plan of eligible indi-
18 viduals with respect to such employee.

19 (c) REQUIRED COVERAGE.—

20 (1) IN GENERAL.—Except as provided in para-
21 graph (2), the required coverage specified in this
22 subsection is standard coverage (consistent with sec-
23 tion 1102(c)), including at least one option (either
24 a fee-for-service option or a point-of-service option)
25 that permits covered individuals an unlimited choice

1 of the lawful providers for which covered benefits are
2 made available.

3 (2) SPECIAL TREATMENT OF SMALL EMPLOY-
4 ERS NOT CONTRIBUTING TO EMPLOYEE COV-
5 ERAGE.—In the case of a small employer (as defined
6 in section 1131(9)) that has not contributed during
7 the previous plan year to the cost of coverage for
8 any eligible employee under any group health plan,
9 the required coverage specified in this subsection for
10 the plan year (with respect to each eligible employee)
11 is—

12 (A) MedAccess standard coverage, with a
13 fee-for-service option and, if available, a point-
14 of-service option and a managed care option (as
15 defined in section 1033);

16 (B) MedAccess catastrophic coverage; and

17 (C) if available, MedAccess medisave cov-
18 erage,

19 as such terms are defined in section 1102(a)(2).

20 (3) CONSTRUCTION.—Nothing in this section
21 shall be construed as limiting the group health
22 plans, or types of coverage under such a plan, that
23 an employer may offer to an employee.

24 (d) 5-YEAR TRANSITION FOR EXISTING GROUP
25 HEALTH PLANS.—

1 (1) IN GENERAL.—The requirement of sub-
 2 section (a)(2) shall not apply to a group health plan
 3 for a plan year if—

4 (A) the group health plan is in effect in
 5 the plan year in which July 1, 1994, occurs,
 6 and

7 (B) the employer makes (or offers to
 8 make), in such plan year and each subsequent
 9 plan year through the plan year involved, a con-
 10 tribution to the plan on behalf of each employee
 11 who is eligible to participate in the plan.

12 (2) SUNSET.—Paragraph (1) shall only apply to
 13 a group health plan for each of the 5 plan years be-
 14 ginning with the first plan year to which the require-
 15 ment of subsection (a) applies.

16 **PART 2—PORTABILITY AND**

17 **NONDISCRIMINATION**

18 **SEC. 1011. NONDISCRIMINATION BASED ON HEALTH STA-**

19 **TUS.**

20 (a) IN GENERAL.—A group health plan and an in-
 21 surer providing health insurance coverage may not deny
 22 or impose (and an insurer may not require an employer
 23 under a group health plan to impose or otherwise to im-
 24 pose through a waiting period for coverage under a plan
 25 or similar requirement) a limitation or exclusion of bene-

1 fits relating to treatment of a condition based on health
2 status or based on the fact that the condition preexisted
3 the effective date of coverage of the individual under the
4 plan if—

5 (1) in the case of any individual eligible for
6 such coverage, such individual has such coverage at
7 the time at which such individual first becomes eligi-
8 ble;

9 (2) the limitation or exclusion applies to an in-
10 dividual who, as of the date of birth, was covered
11 under the plan;

12 (3) the limitation or exclusion relates to preg-
13 nancy;

14 (4) the condition relates to a condition that was
15 not diagnosed or treated within 3 months (or 6
16 months in the case of coverage not under a group
17 health plan) before the date of such coverage; or

18 (5) the limitation or exclusion extends over
19 more than 6 months (or 12 months in the case of
20 coverage not under a group health plan) after the
21 date of such coverage.

22 In the case of an individual who is eligible for coverage
23 but for a waiting period imposed by the employer, in ap-
24 plying paragraphs (4) and (5), the individual shall be

1 treated as having had such coverage as of the earliest date
2 of the beginning of the waiting period.

3 (b) ONE-TIME AMNESTY PERIOD.—

4 (1) IN GENERAL.—In the case of an individual
5 who, as of the first date of the amnesty period is—

6 (A) covered under a group health plan or
7 has health insurance coverage, such coverage
8 shall not be subject to pre-existing condition ex-
9 clusions on and after such date; or

10 (B) not so covered, if the individual ob-
11 tains coverage under a group health plan or
12 health insurance coverage during the next avail-
13 able open enrollment period with respect to the
14 individual, coverage so obtained shall not be
15 subject to pre-existing condition exclusions on
16 and after the effective date of such coverage.

17 (2) AMNESTY PERIOD.—The amnesty period de-
18 scribed in this paragraph, with respect to an individ-
19 ual who is a resident of a State, is the 45-calendar-
20 day period beginning on the effective date of this
21 part (under section 1032(b)).

22 (3) ESTABLISHMENT OF SPECIAL ALLOCATION
23 OF RISK POOL FOR AMNESTY.—Each State shall es-
24 tablish rules and requirements relating to the alloca-
25 tion of risk among insurers with respect to addi-

1 tional risks assumed as a result of the amnesty pe-
2 riod under this subsection (including individuals pre-
3 viously covered for whom a preexisting condition ex-
4 clusion will be no longer applicable).

5 (c) APPLICATION OF RULES BY CERTAIN HEALTH
6 MAINTENANCE ORGANIZATIONS.—A health maintenance
7 organization that provides health insurance coverage shall
8 not be considered as failing to meet the requirements of
9 section 1301 of the Public Health Service Act notwith-
10 standing that it provides for an exclusion of the coverage
11 based on a preexisting condition consistent with the provi-
12 sions of this part so long as such exclusion is applied con-
13 sistent with the provisions of this part.

14 **SEC. 1012. PORTABILITY.**

15 (a) IN GENERAL.—Each group health plan and an
16 insurer providing health insurance coverage shall waive
17 any period applicable to a preexisting condition for similar
18 benefits with respect to an individual to the extent that
19 the individual, immediately prior to the date of such indi-
20 vidual's enrollment in such plan, had health insurance cov-
21 erage for the condition, or was covered for the condition
22 under a group health plan, that was in effect before such
23 date.

24 (b) CONTINUOUS COVERAGE REQUIRED.—

1 (1) IN GENERAL.—Subsection (a) shall no
2 longer apply if there is a continuous period of more
3 than 60 days (or, in the case of an individual de-
4 scribed in paragraph (2), 6 months) for which the
5 individual did not have health insurance coverage for
6 the condition or was not covered under a group
7 health plan for the condition.

8 (2) JOB TERMINATION.—An individual is de-
9 scribed in this paragraph if the individual loses cov-
10 erage under a group health plan due to termination
11 of employment.

12 (3) EXCLUSION OF CASH-ONLY AND DREAD
13 DISEASE PLANS.—In this subsection, the term
14 “group health plan” does not include any group
15 health plan which is offered primarily to provide—

16 (A) coverage for a specified disease or ill-
17 ness, or

18 (B) a hospital or fixed indemnity policy,
19 unless the Secretary determines that such a
20 plan provides sufficiently comprehensive cov-
21 erage of a benefit so that it should be treated
22 as a group health plan under this subsection.

23 (c) TRANSITION FOR NON-CONFORMING POLICIES.—
24 Notwithstanding State law or the provision of any agree-
25 ment to the contrary, effective January 1, 1997, an in-

1 surer may cancel or refuse to renew health insurance cov-
2 erage in a State prior to the application of this subtitle
3 to health insurance coverage issued in the State if the cov-
4 erage does not provide for either standard or catastrophic
5 coverage, but only if the insurer offers the covered individ-
6 ual affected the opportunity to obtain health insurance
7 coverage that meets the applicable requirements of this
8 title.

9 (d) **APPLICABILITY OF COVERAGE UNDER PUBLIC**
10 **INSURANCE.**—In this section, an individual shall be con-
11 sidered to have health insurance coverage for a condition
12 without regard to whether such coverage is under a private
13 or public plan.

14 **SEC. 1013. REQUIREMENTS RELATING TO RENEWABILITY**
15 **GENERALLY.**

16 (a) **MULTIEMPLOYER PLANS AND EXEMPTED MUL-**
17 **TIPLE EMPLOYER HEALTH PLANS.**—A multiemployer
18 plan and an exempted multiple employer health plan may
19 not cancel coverage or deny renewal of coverage under
20 such a plan with respect to an employer other than—

- 21 (1) for nonpayment of contributions,
22 (2) for fraud or other misrepresentation by the
23 employer,
24 (3) for noncompliance with plan provisions, or

1 (4) because the plan is ceasing to provide any
2 coverage in a geographic area.

3 (b) INSURERS.—

4 (1) IN GENERAL.—An insurer may not cancel
5 health insurance coverage or deny renewal of such
6 coverage other than—

7 (A) for nonpayment of premiums,

8 (B) for fraud or other misrepresentation
9 by the insured,

10 (C) for noncompliance with plan provi-
11 sions, or

12 (D) subject to paragraph (2), because the
13 insurer is ceasing to provide any health insur-
14 ance coverage (or the same type of health insur-
15 ance coverage in the same individual or small
16 employer insurance market) in a State, or, in
17 the case of a health maintenance organization
18 or other network plan, in a geographic area.

19 (2) NOTICE REQUIREMENT FOR MARKET
20 EXIT.—Paragraph (1)(D) shall not apply to an in-
21 surer ceasing to provide coverage unless the insurer
22 provides notice of such termination to employers and
23 individuals covered at least 180 days before the date
24 of termination of coverage.

(3) LIMITATION ON REENTRY IN EMPLOYER AND INDIVIDUAL MARKETS.—If an insurer ceases to offer or provide health insurance coverage (or a type of insurance coverage) in an area with respect to the individual or small group market, the insurer may not offer such health insurance coverage (or type of coverage) in the area in such market until 5 years after the date of the termination.

(4) TYPE OF COVERAGE AND INSURANCE MARKET DEFINED.—In this subsection—

(A) MedAccess standard coverage, MedAccess catastrophic coverage, and MedAccess medisave coverage shall each be considered to be separate types of health insurance coverage;

(B) the term “small group market” means the insurance market offered to individuals seeking health care coverage on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to an employer or an association.

1 **PART 3—STANDARDS FOR MANAGED CARE AR-**
2 **RANGEMENTS AND ESSENTIAL COMMUNITY**
3 **PROVIDERS**

4 **SEC. 1021. STANDARDS FOR MANAGED CARE ARRANGE-**
5 **MENTS.**

6 (a) REQUIREMENT.—

7 (1) IN GENERAL.—Each group health plan, and
8 each insurer providing health insurance coverage, for
9 health care through a managed care arrangement
10 shall comply with the applicable requirements of this
11 section.

12 (2) DEFINITIONS.—In this section:

13 (A) MANAGED CARE ARRANGEMENT DE-
14 FINED.—The term “managed care arrange-
15 ment” means, with respect to an arrangement
16 under a group health plan or under health in-
17 surance coverage, providers who have entered
18 into an agreement under the arrangement
19 under which such providers are obligated to
20 provide items and services covered under the ar-
21 rangement to individuals covered under the
22 plan or who have such coverage.

23 (B) PROVIDER NETWORK.—The term
24 “provider network” means, with respect to a
25 group health plan or health insurance coverage,
26 providers who have entered into an agreement

described in subparagraph (A) under a managed care arrangement.

(b) SCOPE OF ARRANGEMENTS WITH PROVIDERS.—

(1) IN GENERAL.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall enter into such agreements with health care providers (including primary and specialty providers for children) or have such other arrangements as may be necessary to assure that covered individuals have reasonably prompt access through the entity's provider network to all items and services contained in the package of benefits for which coverage is provided (including access to emergency services on a 24-hour basis where medically necessary), in a manner that assures the continuity of the provision of such items and services.

(2) ACCESS TO CENTERS OF EXCELLENCE.—

(A) IN GENERAL.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall demonstrate that covered individuals (including individuals with chronic diseases) have access through the entity's provider network to specialized treatment expertise of

1 designated centers of excellence. Such entity
2 shall demonstrate such access according to
3 standards developed by the Secretary, including
4 requirements relating to arrangements with
5 such centers and referral of patients to such
6 centers.

7 (B) DESIGNATION OF CENTERS OF EXCEL-
8 LENCE.—The Secretary shall establish a proc-
9 ess for the designation of facilities, including
10 children's hospitals and other pediatric facili-
11 ties, as centers of excellence for purposes of this
12 paragraph. A facility may not be designated un-
13 less the facility is determined—

14 (i) to provide specialty care,

15 (ii) to deliver care for complex cases
16 requiring specialized treatment and for in-
17 dividuals with chronic diseases, and

18 (iii) to meet other requirements that
19 may be established by the Secretary relat-
20 ing to specialized education and training of
21 health professionals, participation in peer-
22 reviewed research, or treatment of patients
23 from outside the geographic area of the fa-
24 cility.

1 (3) NO REFERRAL REQUIRED FOR OBSTETRICS
2 AND GYNECOLOGY.—An entity providing for a man-
3 aged care arrangement may not require an individ-
4 ual to obtain a referral from a physician in order to
5 obtain covered items and services within the network
6 of the arrangement from a physician who specializes
7 in obstetrics and gynecology.

8 (c) PROVISION OF EMERGENCY AND URGENT CARE
9 SERVICES.—

10 (1) IN GENERAL.—The entity providing for a
11 managed care arrangement on behalf of a group
12 health plan or under health insurance coverage must
13 cover medically necessary emergency and urgent
14 care services provided to covered individuals (includ-
15 ing trauma services provided by designated trauma
16 centers), without regard to whether or not the pro-
17 vider furnishing such services has a contractual (or
18 other) arrangement with the entity to provide items
19 or services to covered individuals and, in the case of
20 services furnished for the treatment of an emergency
21 medical condition (as defined in section 1867(e)(1)
22 of the Social Security Act), without regard to prior
23 authorization.

(2) DESIGNATED TRAUMA CENTERS DEFINED.—In paragraph (1), the term “designated trauma center”—

(A) has the meaning given such term in section 1231 of the Public Health Service Act, and

(B) includes (for years prior to 2001) a trauma center that—

(i) is located in a State that has not designated trauma centers under section 1213 of such Act, and

(ii) the Secretary finds meets the standards under such section to be a designated trauma center.

(d) DUE PROCESS STANDARDS RELATING TO PROVIDER NETWORKS.—

(1) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—

(A) ESTABLISHMENT.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall establish standards to be used by the entity for contracting with health care providers with respect the entity’s provider network. Such standards shall be established in

1 consultation with providers who are members of
2 the network.

3 (B) DISTRIBUTION OF INFORMATION.—
4 Descriptive information regarding these stand-
5 ards shall be made available upon request to en-
6 rollees, providers who are members of the net-
7 work, and prospective enrollees and prospective
8 participating providers.

9 (2) NOTICE REQUIREMENT.—

10 (A) IN GENERAL.—The entity may not ter-
11minate or refuse to renew an agreement with a
12 provider to participate in the entity's provider
13 network unless the entity provides written noti-
14 fication to the provider of the entity's decision
15 to terminate or to refuse to renew the agree-
16 ment. The notification shall include a statement
17 of the reasons for the entity's decision, consist-
18 ent with the standards established under para-
19 graph (1).

20 (B) TIMING OF NOTIFICATION.—The en-
21 tity shall provide the notification required under
22 subparagraph (A) at least 45 days prior to the
23 effective date of the termination or expiration of
24 the agreement (whichever is applicable). The
25 previous sentence shall not apply if failure to

1 terminate the agreement prior to the deadline
2 would adversely affect the health or safety of a
3 covered individual.

4 (3) REVIEW PROCESS.—

5 (A) IN GENERAL.—The entity shall provide
6 a process under which the provider may request
7 a review of the entity's decision to terminate or
8 refuse to renew the provider's participation
9 agreement. Such review shall be conducted by a
10 group of individuals the majority of whom are
11 health care providers who are members of the
12 entity's provider network or employees of the
13 entity, and who are members of the same pro-
14 fession as the provider who requests the review.

15 (B) COUNSEL.—If the provider requests in
16 advance, the entity shall permit an attorney
17 representing the provider to be present at the
18 provider's review.

19 (C) REVIEW ADVISORY.—The findings and
20 conclusions of a review under this paragraph
21 shall be advisory and non-binding.

22 (4) CONSTRUCTION.—Nothing in this sub-
23 section shall be construed to affect any other provi-
24 sion of law that provides an appeals process or other
25 form of relief to a provider of health care services.

1 **SEC. 1022. UTILIZATION REVIEW.**

2 (a) **REQUIRING REVIEW TO MEET STANDARDS.**—A
3 group health plan or insurer providing health insurance
4 coverage may not deny coverage of or payment for items
5 and services on the basis of a utilization review program
6 unless the program meets the standards established by the
7 Secretary under this section.

8 (b) **ESTABLISHMENT OF STANDARDS BY SEC-**
9 **RETARY.**—The Secretary shall establish standards for uti-
10 lization review programs, consistent with subsection (c),
11 and shall periodically review and update such standards
12 to reflect changes in the delivery of health care services.
13 The Secretary shall establish such standards in consulta-
14 tion with appropriate parties, including representatives of
15 health care providers, specialists, insurers, plan adminis-
16 trators, and other experts.

17 (c) **REQUIREMENTS FOR STANDARDS.**—Under the
18 standards established under subsection (a)—

19 (1) individuals performing utilization review
20 may not receive financial compensation based upon
21 the number of denials of coverage;

22 (2) negative determinations of the medical ne-
23 cessity or appropriateness of services or the site at
24 which services are furnished may be made only by
25 clinically qualified personnel;

1 (3) the utilization review program shall provide
2 for a process under which an enrollee or provider
3 may obtain timely review of a denial of coverage;

4 (4) utilization review shall be conducted in ac-
5 cordance with uniformly applied standards that are
6 based on the most currently available medical evi-
7 dence; and

8 (5) providers shall participate in the develop-
9 ment of the utilization review program.

10 (d) PREEMPTION.—For provision preempting State
11 laws relating to utilization review, see section 1203(a)(3).

12 **PART 4—ENFORCEMENT; EFFECTIVE DATES;**

13 **DEFINITIONS**

14 **SEC. 1031. ENFORCEMENT.**

15 (a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR
16 EMPLOYERS AND GROUP HEALTH PLANS.—

17 (1) IN GENERAL.—For purposes of part 5 of
18 subtitle B of title I of the Employee Retirement In-
19 come Security Act of 1974, the provisions of parts
20 1 and 2 of this subtitle and part 1 of subtitle B
21 shall be deemed to be provisions of title I of such
22 Act irrespective of exclusions under section 4(b) of
23 such Act.

24 (2) REGULATORY AUTHORITY.—With respect to
25 the regulatory authority of the Secretary of Labor

under this subtitle pursuant to subsection (a), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT BY PENALTY FOR INSURERS.—

(1) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end thereof the following new section:

**“SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH
HEALTH INSURANCE STANDARDS.**

“(a) IMPOSITION OF PENALTY.—

“(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer to comply with the requirements applicable to the insurer under parts 2 and 3 of subtitle A of title I and subtitle B of the Affordable Health Care Now Act of 1994.

“(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by an insurer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

“(b) AMOUNT OF PENALTY.—

“(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a)

1 shall be \$100 for each day during which such failure
2 persists for each individual to which such failure re-
3 lates. A rule similar to the rule of section
4 4980B(b)(3) shall apply for purposes of this section.

5 “(2) LIMITATION.—The amount of the tax im-
6 posed by subsection (a) for an insurer with respect
7 to health insurance coverage shall not exceed 25 per-
8 cent of the amounts received for such coverage dur-
9 ing the period such failure persists.

10 “(c) LIABILITY FOR PENALTY.—The penalty imposed
11 by this section shall be paid by the insurer.

12 “(d) EXCEPTIONS.—

13 “(1) CORRECTIONS WITHIN 30 DAYS.—No tax
14 shall be imposed by subsection (a) by reason of any
15 failure if—

16 “(A) such failure was due to reasonable
17 cause and not to willful neglect, and

18 “(B) such failure is corrected within the
19 30-day period beginning on the earliest date the
20 insurer knew, or exercising reasonable diligence
21 would have known, that such failure existed.

22 “(2) WAIVER BY SECRETARY.—In the case of a
23 failure which is due to reasonable cause and not to
24 willful neglect, the Secretary may waive part or all
25 of the tax imposed by subsection (a) to the extent

1 that payment of such tax would be excessive relative
2 to the failure involved.

3 “(e) DEFINITIONS.—For purposes of this section, the
4 terms ‘health insurance coverage’ and ‘insurer’ have the
5 respective meanings given such terms in section 1033 of
6 the Affordable Health Care Now Act of 1994.”

7 (2) CLERICAL AMENDMENT.—The table of sec-
8 tions for chapter 43 of such Code is amended by
9 adding at the end thereof the following new items:

“Sec. 4980C. Failure of insurer to comply with health insurance
standards.”

10 **SEC. 1032. EFFECTIVE DATES.**

11 (a) PART 1.—The requirements of part 1 shall apply
12 to plans years beginning after December 31, 1996.

13 (b) PARTS 2 AND 3.—The requirements of parts 2
14 and 3 shall apply with respect to—

15 (1) group health plans and employers shall
16 apply to plans years beginning after December 31,
17 1996, and

18 (2) insurers shall take effect on January 1,
19 1997.

20 **SEC. 1033. DEFINITIONS AND SPECIAL RULES.**

21 (a) IN GENERAL.—For purposes of this subtitle:

22 (1) DEPENDENT.—The term “dependent”
23 means, with respect to any individual, any person
24 who is—

1 (A) the spouse or surviving spouse of the
2 individual, or

3 (B) under regulations of the Secretary, a
4 child (including an adopted child) of such indi-
5 vidual and—

6 (i) under 19 years of age, or

7 (ii) under 25 years of age and a full-
8 time student.

9 (2) ELIGIBLE EMPLOYEE.—The term “eligible
10 employee” means, with respect to an employer, an
11 employee who normally performs on a monthly basis
12 at least 10 hours of service per week for that em-
13 ployer. Such term shall not include any employee
14 who is not reasonably expected as of the 1st day of
15 a month to be employed by the employer for a period
16 of 120 consecutive days during any 365-day period
17 that includes such 1st day.

18 (3) ELIGIBLE INDIVIDUAL.—The term “eligible
19 individual” means, with respect to an eligible em-
20 ployee, such employee, and any dependent of such
21 employee.

22 (4) EMPLOYER.—The term “employer” shall
23 have the meaning applicable under section 3(5) of
24 the Employee Retirement Income Security Act of
25 1974.

1 (5) EXEMPTED MULTIPLE EMPLOYER HEALTH
2 PLAN.—The term “exempted multiple employer
3 health plan” means a multiple employer welfare ar-
4 rangement treated as an employee welfare benefit
5 plan by reason of an exemption under part 7 of sub-
6 title B of title I of the Employee Retirement Income
7 Security Act of 1974 (as added by part 2 of subtitle
8 C of this title).

9 (6) GROUP HEALTH PLAN; PLAN.—(A) The
10 term “group health plan” means an employee wel-
11 fare benefit plan providing medical care (as defined
12 in section 213(d) of the Internal Revenue Code of
13 1986) to participants or beneficiaries directly or
14 through insurance, reimbursement, or otherwise, but
15 does not include any type of coverage excluded from
16 the definition of a health insurance coverage under
17 section 1131(4)(B).

18 (B) The term “plan” means a group health
19 plan (including any such plan which is a multiem-
20 ployer plan) and an exempted multiple employer
21 health plan.

22 (7) HEALTH INSURANCE COVERAGE.—The term
23 “health insurance coverage” shall have the meaning
24 applicable under section 1131(4).

1 (8) FULLY INSURED.—The term “fully in-
2 sured” shall have the meaning applicable under sec-
3 tion 701(9) of Employee Retirement Income Secu-
4 rity Act of 1974 (as added by section 1211 of this
5 title).

6 (9) INSURER.—The term “insurer” has the
7 meaning given such term in section 1131(6).

8 (10) MULTIPLE EMPLOYER WELFARE AR-
9 RANGEMENT.—The term “multiple employer welfare
10 arrangement” shall have the meaning applicable
11 under section 3(40) of the Employee Retirement In-
12 come Security Act of 1974.

13 (11) OPTIONS.—

14 (A) FEE-FOR-SERVICE OPTION.—Standard
15 coverage is considered to provide a “fee-for-
16 service option” if benefits with respect to the
17 covered items and services in the coverage are
18 made available for such items and services pro-
19 vided through any lawful provider of such cov-
20 ered items and services.

21 (B) MANAGED CARE OPTION.—Standard
22 coverage is considered to provide a “managed
23 care option” if benefits with respect to the cov-
24 ered items and services in the coverage are
25 made available exclusively through a managed

1 care arrangement (as defined in section
2 1021(a)(2)), except in the case of emergency
3 and urgent services and as otherwise required
4 under law.

5 (C) POINT-OF-SERVICE OPTION.—Standard
6 coverage is considered to provide a “point-of-
7 service option” if the benefits with respect to
8 covered items and services in the coverage are
9 made available principally through a managed
10 care arrangement, with the choice of the en-
11 rollee to obtain such benefits for items and
12 services provided through any lawful provider of
13 such covered items and services. The coverage
14 may provide for different cost sharing schedules
15 based on whether the items and services are
16 provided through such an arrangement or out-
17 side such an arrangement.

18 (b) APPLICATION OF ERISA DEFINITIONS.—Except
19 as otherwise provided in this subtitle, terms used in this
20 subtitle shall have the meanings applicable to such terms
21 under section 3 of the Employee Retirement Income Secu-
22 rity Act of 1974 (29 U.S.C. 1002).

23 (c) SECRETARY.—Except with respect to references
24 specifically to the Secretary of Labor, the term “Sec-

1 retary” means the Secretary of Health and Human Serv-
 2 ices.

3 **Subtitle B—Reform of Health** 4 **Insurance**

5 **PART 1—MARKETPLACE FOR SMALL BUSINESS**

6 **SEC. 1101. REQUIREMENT FOR INSURERS TO OFFER** 7 **MEDACCESS COVERAGE.**

8 (a) REQUIREMENT.—

9 (1) IN GENERAL.—Each insurer (as defined in
 10 section 1131(6)) that makes available any health in-
 11 surance coverage (as defined in section 1131(4)) to
 12 a small employer (as defined in section 1131(9)) in
 13 a State—

14 (A) shall make available to each small em-
 15 ployer in the State MedAccess standard cov-
 16 erage (as defined in section 1102(a)(2)), with a
 17 fee-for-service option and, if available, a point-
 18 of-service option and a managed care option (as
 19 defined in section 1033),

20 (B) shall make available to each small em-
 21 ployer in the State MedAccess catastrophic cov-
 22 erage (as defined in section 1102(a)(2)), and

23 (C) may make available to each small em-
 24 ployer in the State MedAccess medisave cov-
 25 erage (as defined in section 1102(a)(2)).

(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirements of paragraph (1)(A) (with regard to requiring a fee-for-service option), and paragraphs (1)(B) and (1)(C) shall not apply with respect to a health insurance coverage that—

(A) is provided by a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), or

(B) is not provided by such an organization but is provided by an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

(3) EXCEPTION IF STATE PROVIDES FOR GUARANTEED AVAILABILITY (RATHER THAN GUARANTEED ISSUE).—Paragraph (1) shall not apply to an insurer in a State if the State is providing—

(A) access to each small employer in the State to MedAccess standard coverage, to MedAccess catastrophic coverage, and to a MedAccess medisave coverage, and

1 (B) a risk allocation mechanism described
2 in subsection (c).

3 (b) GUARANTEED ISSUE OF MEDACCESS COV-
4 ERAGE.—Subject to subsection (c)—

5 (1) IN GENERAL.—Subject to paragraphs (2)
6 and (3), each insurer that offers MedAccess cov-
7 erage to a small employer in a State—

8 (A) must accept every small employer in
9 the State that applies for such coverage; and

10 (B) must accept for enrollment under such
11 coverage every eligible individual (as defined in
12 paragraph (5)) who applies for enrollment on a
13 timely basis (consistent with paragraph (4))
14 and may not place any restriction on the eligi-
15 bility of an individual to enroll so long as such
16 individual is an eligible individual.

17 (2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of coverage of-
18 fered by a health maintenance organization or other
19 network plan, the organization may—

21 (A) limit the employers that may apply for
22 such coverage to those with eligible individuals
23 residing in the service area of the plan;

(B) limit the individuals who may be enrolled under such coverage to those who reside in the service area for such organization; and

(C) within the service area of such organization, deny such coverage to such employers if the organization demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this subparagraph uniformly to all employers without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

In this paragraph, the term “health maintenance organization” includes an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

(3) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—In the case of coverage offered by an insurer other than a health maintenance organization or network plan, the insurer may deny such coverage

1 to small employers if the organization demonstrates
2 that—

3 (A) it does not have the financial reserves
4 necessary to underwrite additional coverage,
5 and

6 (B) it is applying this paragraph uniformly
7 to all employers without regard to the health
8 status, claims experience, or duration of cov-
9 erage of those employers and their employees.

10 (4) CLARIFICATION OF TIMELY ENROLL-
11 MENT.—

12 (A) GENERAL INITIAL ENROLLMENT RE-
13 QUIREMENT.—Except as provided in this para-
14 graph, enrollment of an eligible individual for
15 MedAccess coverage may be considered not to
16 be timely if the eligible employee or dependent
17 fails to enroll under such coverage during an
18 initial enrollment period, if such period is at
19 least 30 days long.

20 (B) ENROLLMENT DUE TO LOSS OF PRE-
21 VIOUS COVERAGE.—Enrollment under
22 MedAccess coverage is considered to be timely
23 in the case of an eligible individual who—

24 (i) was covered under a group health
25 plan or had other health insurance cov-

1 erage at the time of the individual's initial
2 enrollment period,

3 (ii) stated at the time of the initial en-
4 rollment period that coverage under a
5 group health plan or other health insur-
6 ance coverage was the reason for declining
7 enrollment,

8 (iii) lost coverage under a group
9 health plan or other health insurance cov-
10 erage (as a result of the termination of the
11 coverage, termination or reduction of em-
12 ployment, or other reason), and

13 (iv) requests enrollment within 30
14 days after termination of the coverage.

15 (C) REQUIREMENT APPLIES DURING OPEN
16 ENROLLMENT PERIODS.—Each insurer and
17 each group health plan providing MedAccess
18 coverage shall provide for at least one period (of
19 not less than 30 days) each year during which
20 enrollment under such coverage shall be consid-
21 ered to be timely.

22 (D) EXCEPTION FOR COURT ORDERS.—
23 Enrollment of a spouse or minor child of an
24 employee shall be considered to be timely if—

1 (i) a court has ordered that coverage
 2 be provided for the spouse or child under
 3 a covered employee's group health plan,
 4 and

5 (ii) a request for enrollment is made
 6 within 30 days after the date the court is-
 7 sues the order.

8 (E) ENROLLMENT OF SPOUSES AND DE-
 9 PENDENTS.—

10 (i) IN GENERAL.—Enrollment of the
 11 spouse (including a child of the spouse)
 12 and any dependent child of an eligible em-
 13 ployee shall be considered to be timely if a
 14 request for enrollment is made either—

15 (I) within 30 days of the date of
 16 the marriage or of the date of the
 17 birth or adoption of a child, if family
 18 coverage is available as of such date,
 19 or

20 (II) within 30 days of the date
 21 family coverage is first made avail-
 22 able.

23 (ii) COVERAGE.—If available coverage
 24 includes family coverage and enrollment is
 25 made under such coverage on a timely

basis under clause (i)(I), the coverage shall become effective not later than the first day of the first month beginning after the date of the marriage or the date of birth or adoption of the child (as the case may be).

(5) DEFINITIONS.—In this subsection, the terms “eligible individual” and “group health plan” have the meanings given such terms in section 1023(a).

(c) STATE OPTION OF GUARANTEED AVAILABILITY THROUGH ALLOCATION OF RISK (RATHER THAN THROUGH GUARANTEED ISSUE).—The requirements of subsection (b) shall not apply in a State if the State has provided (in accordance with standards established under this part) a mechanism under which—

(1) each insurer offering health insurance coverage to a small employer in the State must participate in a program for assigning high-risk small employer groups (or individuals within such a group) among some or all such insurers, and

(2) the insurers to which such high-risk small employer groups or individuals are so assigned comply with the requirements of subsection (b).

1 **SEC. 1102. MEDACCESS COVERAGE DEFINED.**

2 (a) MEDACCESS COVERAGE DEFINED.—In this sub-
3 title:

4 (1) IN GENERAL.—The term “MedAccess cov-
5 erage” means a health insurance coverage (whether
6 under a managed-care plan, indemnity plan, or other
7 plan) that meets the following requirements:

8 (A) The coverage—

9 (i) is designed to provide standard
10 coverage (consistent with subsection (c))
11 with substantial cost-sharing,

12 (ii) is designed to provide only cata-
13 strophic coverage (consistent with sub-
14 section (d)), or

15 (iii) is designed to provide medisave
16 coverage (consistent with subsection (e)).

17 (B) The coverage includes only services, in-
18 cluding (but not limited to) medical, surgical,
19 hospital, and preventive services, which are es-
20 sential and medically necessary; except that no
21 specific procedure or treatment, or classes
22 thereof, is required to be included in such cov-
23 erage, by this Act or through regulations.

24 (C) The coverage meets the applicable re-
25 quirements of section 1101(b) (relating to guar-
26 anteed issue).

(D) The coverage meets the consumer protection standards established under section 1103(a)(1)(B).

(2) MEDACCESS STANDARD, CATASTROPHIC, AND MEDISAVE COVERAGE.—The terms “MedAccess standard coverage”, “MedAccess catastrophic coverage”, “MedAccess medisave coverage” mean MedAccess coverage that provides for at least standard coverage (referred to in paragraph (1)(A)(i)), for only catastrophic coverage (referred to in paragraph (1)(A)(ii)), or medisave coverage (referred to in paragraph (1)(A)(iii)), respectively.

(b) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

(1) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a set of rules, including an appropriate set of safe harbors, which the NAIC determines is sufficient for determining, in the case of any health insurance coverage and for purposes of this section, the actuarial value of the coverage offered.

(2) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules that comply with the requirements of paragraph (1), the Secretary shall certify such set of rules for use

1 under this part. If the Secretary determines that
2 such a set of rules has not been submitted or does
3 not comply with such requirements, the Secretary
4 shall promptly establish a set of rules that meets
5 such requirements.

6 (c) STANDARD COVERAGE.—

7 (1) IN GENERAL.—For purposes of this Act,
8 health insurance coverage is considered to provide
9 standard coverage consistent with this subsection if
10 the benefits are specified in a written instrument
11 providing for such coverage as essential and medi-
12 cally necessary services described in subsection
13 (a)(1)(B) and determined, in accordance with the set
14 of actuarial equivalence rules certified under sub-
15 section (b), to have a value that is within 5 percent-
16 age points of the applicable target actuarial value
17 for standard coverage established under paragraph
18 (2).

19 (2) INITIAL DETERMINATION OF APPLICABLE
20 TARGET ACTUARIAL VALUE FOR STANDARD COV-
21 ERAGE.—

22 (A) INITIAL DETERMINATION.—The NAIC
23 is requested to submit to the Secretary, within
24 6 months after the date of the enactment of
25 this Act, a procedure for determining the appli-

1 cable target actuarial value for standard cov-
2 erage (which may vary by geographic area).
3 Such value shall be equal to the average actuar-
4 ial value of a representative range of the dif-
5 ferent types of health benefits provisions (which
6 include cost-sharing) typically offered as stand-
7 ard coverage in the small employer health cov-
8 erage market. In determining the actuarial
9 value, the benefits considered should be suffi-
10 cient to cover only services, including (but not
11 limited to) medical, surgical, hospital, and pre-
12 ventive services, which are essential and medi-
13 cally necessary; except that no specific proce-
14 dure or treatment, or classes thereof, is re-
15 quired to be considered in such determination
16 by this Act or through regulations. The deter-
17 mination of such value shall be based on a rep-
18 resentative distribution of the population of eli-
19 gible employees offered such coverage and a
20 single set of standardized utilization and cost
21 factors (which may vary by geographic area).

22 (B) CERTIFICATION.—If the Secretary de-
23 termines that the NAIC has submitted a proce-
24 dure for determining the applicable target actu-
25 arial value for standard coverage that complies

1 with the requirements of subparagraph (A), the
2 Secretary shall certify such procedure for use
3 under this part. If the Secretary determines
4 that such a procedure has not been submitted
5 or does not comply with such requirements, the
6 Secretary shall promptly prescribe such a proce-
7 dure that meets such requirements.

8 (d) CATASTROPHIC COVERAGE.—

9 (1) IN GENERAL.—For purposes of subsection
10 (a)(1)(B), health insurance coverage is considered to
11 provide catastrophic coverage consistent with this
12 subsection if—

13 (A) benefits are available under such cov-
14 erage for a year only to the extent that ex-
15 penses for covered services in a year exceed a
16 deductible amount that is consistent with the
17 dollar amounts specified in section 220(c)(2)(A)
18 of the Internal Revenue Code of 1986, as added
19 by section 2202, and

20 (B) the benefits are determined, in accord-
21 ance with the set of actuarial equivalence rules
22 certified under subsection (b), to have a value
23 that is within 5 percentage points of the target
24 actuarial value for catastrophic coverage estab-
25 lished under paragraph (2).

(2) INITIAL DETERMINATION OF TARGET ACTUARIAL VALUE FOR CATASTROPHIC COVERAGE.—

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a target actuarial value for catastrophic coverage equal to the actuarial value that would have been computed under subsection (c)(2)(A) if a deductible that represents the midpoint of the range of deductibles permitted consistent with subsections (b)(2) and (c)(2)(A) of section 220 of the Internal Revenue Code of 1986 were used in place of any deductible that otherwise would be applicable.

(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a target actuarial value for catastrophic coverage that comply with the requirements of subparagraph (A), the Secretary shall certify such value for use under this part. If the Secretary determines that such a value has not been submitted or does not comply with such requirements, the Secretary shall promptly determine such a target actuarial value that meets such requirements.

1 (e) MEDISAVE COVERAGE.—

2 (1) IN GENERAL.—For purposes of subsection
3 (a)(1)(C), health insurance coverage is considered to
4 provide medisave coverage consistent with this sub-
5 section if such coverage consists of—

6 (A) coverage under a catastrophic health
7 plan (within the meaning of section 220(c)(2)
8 of the Internal Revenue Code of 1986, as in-
9 serted by section 2202 of this Act), and

10 (B) a medical savings account described in
11 section 220(d)(1)(B) of such Code.

12 (f) SUBSEQUENT REVISIONS.—

13 (1) NAIC.—The NAIC may submit from time
14 to time to the Secretary revisions of the set of rules
15 of actuarial equivalence previously established or de-
16 termined under this section if the NAIC determines
17 such revision necessary to take into account changes
18 in the relevant types of health benefits provisions, in
19 deductible levels for catastrophic coverage, or in de-
20 mographic conditions which form the basis for such
21 set of rules. The provisions of subsection (b)(2) shall
22 apply to such a revision in the same manner as they
23 apply to the initial determination of the set of rules.

24 (2) SECRETARY.—The Secretary may by regu-
25 lation revise such set of rules and values from time

1 to time if the Secretary determines such revision
2 necessary to take into account changes described in
3 paragraph (1).

4 **SEC. 1103. ESTABLISHMENT OF OTHER MEDACCESS STAND-**
5 **ARDS.**

6 (a) ESTABLISHMENT OF GENERAL STANDARDS.—

7 (1) ROLE OF NAIC.—The Secretary shall re-
8 quest the NAIC to develop, within 9 months after
9 the date of the enactment of this Act, model regula-
10 tions that specify standards with respect to each of
11 the following:

12 (A)(i) The requirement, under section
13 1101(a), that insurers make available
14 MedAccess coverage.

15 (ii) The requirements of guaranteed avail-
16 ability of MedAccess coverage to small employ-
17 ers under section 1101(b).

18 (B) The requirements of section 1104 (re-
19 lating to use of modified community rating, uni-
20 form marketing materials, and miscellaneous
21 consumer protections).

22 If the NAIC develops recommended regulations
23 specifying such standards within such period, the
24 Secretary shall review the standards. Such review
25 shall be completed within 60 days after the date the

1 regulations are developed. Unless the Secretary de-
2 termines within such period that the standards do
3 not meet the requirements, such standards shall
4 serve as the standards under this section, with such
5 amendments as the Secretary deems necessary.

6 (2) CONTINGENCY.—If the NAIC does not de-
7 velop such model regulations within such period or
8 the Secretary determines that such regulations do
9 not specify standards that meet the requirements de-
10 scribed in paragraph (1), the Secretary shall specify,
11 within 15 months after the date of the enactment of
12 this Act, standards to carry out those requirements.

13 (3) EFFECTIVE DATE.—The MedAccess stand-
14 ards and consumer protection standards (as defined
15 in paragraph (5)) shall apply to MedAccess coverage
16 and health insurance coverage provided in a State
17 on or after the respective date the standards are im-
18 plemented in the State under subsections (b) and
19 (c).

20 (4) PREEMPTION OF STATE LAW.—

21 (A) IN GENERAL.—Except as provided in
22 subparagraph (B), a State may not establish or
23 enforce standards for health insurance coverage
24 made available to small employers and individ-

uals that are different from the standards established under this part.

(B) GRANDFATHER.—In the case of a State that, as of August 1, 1994, required that premiums in the individual and small group market sectors be community-rated and not vary based on age, the State continue such standards (and reasonable modifications thereof) in force.

(5) DEFINITIONS.—In this section:

(A) CONSUMER PROTECTION STANDARDS.—The term “consumer protection standards” means the standards established under paragraph (1)(B).

(B) MEDACCESS STANDARDS.—The term “MedAccess standards” means the standards established under paragraph (1)(A) (relating to the requirements of section 1101), and includes the consumer protection standards insofar as they relate to MedAccess coverage.

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF MEDACCESS STANDARDS.—

1 (A) IN GENERAL.—Each State shall sub-
 2 mit to the Secretary, by the deadline specified
 3 in subparagraph (B), a report on steps the
 4 State is taking to implement and enforce the
 5 consumer protection standards with respect to
 6 insurers, and MedAccess coverage offered, not
 7 later than such deadline.

8 (B) DEADLINE FOR REPORT.—

9 (i) 1 YEAR AFTER STANDARDS ESTAB-
 10 LISHED.—Subject to clause (ii), the dead-
 11 line under this subparagraph is 1 year
 12 after the date the MedAccess standards
 13 are established under subsection (a).

14 (ii) EXCEPTION FOR LEGISLATION.—

15 In the case of a State which the Secretary
 16 identifies, in consultation with the NAIC,
 17 as—

18 (I) requiring State legislation
 19 (other than legislation appropriating
 20 funds) in order for insurers and plans
 21 providing MedAccess coverage offered
 22 to meet the MedAccess standards es-
 23 tablished under subsection (a), but

24 (II) having a legislature which is
 25 not scheduled to meet in 1995 in a

legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the MedAccess standards under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as

1 the Secretary determines to be appropriate. Such
2 implementation and enforcement shall take effect
3 with respect to insurers, and plans providing
4 MedAccess coverage offered or renewed, on or after
5 3 months after the date of the Secretary's finding
6 under the previous sentence, and until the date the
7 Secretary finds that such a failure has been cor-
8 rected. In exercising authority under this subpara-
9 graph, the Secretary shall determine whether the use
10 of a risk-allocation mechanism, described in section
11 1101(c), would be more consistent with the small
12 employer group health coverage market in the State
13 than the guaranteed availability provisions of section
14 1101(b).

15 (3) APPLICATION OF CONSUMER PROTECTION
16 STANDARDS.—

17 (A) IN GENERAL.—Each State shall sub-
18 mit to the Secretary, by the deadline specified
19 in subparagraph (B), a report on steps the
20 State is taking to implement and enforce the
21 MedAccess standards with respect to insurers,
22 and health insurance coverage (other than
23 MedAccess coverage) offered, not later than
24 such deadline.

25 (B) DEADLINE FOR REPORT.—

1 (i) 1 YEAR AFTER STANDARDS ESTAB-
2 LISHED.—Subject to clause (ii), the dead-
3 line under this subparagraph is 1 year
4 after the date the consumer protection
5 standards are established under subsection
6 (a).

7 (ii) EXCEPTION FOR LEGISLATION.—
8 In the case of a State which the Secretary
9 identifies, in consultation with the NAIC,
10 as—

11 (I) requiring State legislation
12 (other than legislation appropriating
13 funds) in order for insurers and plans
14 providing health insurance coverage
15 offered to meet the consumer protec-
16 tion standards established under sub-
17 section (a), but

18 (II) having a legislature which is
19 not scheduled to meet in 1995 in a
20 legislative session in which such legis-
21 lation may be considered,
22 the date specified in this subparagraph is
23 the first day of the first calendar quarter
24 beginning after the close of the first legis-
25 lative session of the State legislature that

1 begins on or after January 1, 1996. For
2 purposes of the previous sentence, in the
3 case of a State that has a 2-year legislative
4 session, each year of such session shall be
5 deemed to be a separate regular session of
6 the State legislature.

7 (4) FEDERAL ROLE.—If the Secretary deter-
8 mines that a State has failed to submit a report by
9 the deadline specified under paragraph (1) or finds
10 that the State has not implemented and provided
11 adequate enforcement of the consumer protection
12 standards under such paragraph, the Secretary shall
13 notify the State and provide the State a period of
14 60 days in which to submit such report or to imple-
15 ment and enforce such standards under such para-
16 graph. If, after such 60-day period, the Secretary
17 finds that such a failure has not been corrected, the
18 Secretary shall provide for such mechanism for the
19 implementation and enforcement of such standards
20 in the State as the Secretary determines to be ap-
21 propriate. Such implementation and enforcement
22 shall take effect with respect to insurers, and health
23 insurance coverage (other than MedAccess coverage)
24 offered or renewed, on or after 3 months after the
25 date of the Secretary's finding under the previous

1 sentence, and until the date the Secretary finds that
2 such a failure has been corrected.

3 **SEC. 1104. USE OF MODIFIED COMMUNITY RATING, UNI-**
4 **FORM MARKETING MATERIALS, AND MIS-**
5 **CELLANEOUS CONSUMER PROTECTIONS.**

6 (a) **USE OF MODIFIED COMMUNITY RATING.—**

7 (1) **IN GENERAL.**—As a standard under section
8 1103(a)(1)(B), subject to paragraph (2), the pre-
9 mium rate established by an insurer for coverage
10 may not vary within a plan design except by the fol-
11 lowing:

12 (A) **AGE.**—By age, based on classes of age
13 established by a State.

14 (B) **GEOGRAPHIC AREA.**—By geographic
15 area, based on 3-digit zip code or counties, as
16 identified by a State.

17 (C) **FAMILY SIZE.**—Family size, based on
18 a classification of individual, individual with one
19 or more children, married couple without chil-
20 dren, and married couple with children.

21 (2) **DISCOUNT FOR EMPLOYER WELLNESS PRO-**
22 **GRAM.**—An insurer may provide for a group dis-
23 count with respect to an employer that provides for
24 a wellness program for employees.

1 (b) FULL DISCLOSURE OF RATING PRACTICES.—At
2 the time an insurer offers health insurance coverage to
3 a small employer, the insurer shall fully disclose to the
4 employer rating practices for health insurance coverage,
5 including rating practices for different plan designs.

6 (c) ACTUARIAL CERTIFICATION.—Each insurer that
7 offers health insurance coverage to a small employer in
8 a State shall file annually with the State commissioner of
9 insurance a written statement by a member of the Amer-
10 ican Academy of Actuaries (or other individual acceptable
11 to the commissioner) that, based upon an examination by
12 the individual which includes a review of the appropriate
13 records and of the actuarial assumptions of the insurer
14 and methods used by the insurer in establishing premium
15 rates for applicable health insurance coverage—

16 (1) the insurer is in compliance with the appli-
17 cable provisions of this section, and

18 (2) the rating methods are actuarially sound.

19 Each such insurer shall retain a copy of such statement
20 for examination at its principal place of business.

21 (d) REGISTRATION AND REPORTING.—Each insurer
22 that issues any health insurance coverage to a small em-
23 ployer in a State shall be registered or licensed with the
24 State commissioner of insurance and shall comply with

1 any reporting requirements of the commissioner relating
2 to such coverage.

3 (e) **MARKETING MATERIAL.**—Each insurer that is-
4 sues any health insurance coverage to a small employer
5 in a State shall file with the State those marketing mate-
6 rials relating to the offer and sale of health insurance cov-
7 erage to be used for distribution before the materials are
8 used. Such materials shall be in a uniform format speci-
9 fied under the standards established under section 1101.
10 Such materials (including information on plan designs of-
11 fered by different insurers) shall be distributed to employ-
12 ers that do not contribute to health insurance coverage
13 for their employees, in order to distribute such informa-
14 tion to their employees as part of the offer of coverage
15 under section 1001(a).

16 **SEC. 1105. MONITORING AND RESPONSE TO ADVERSE SE-**
17 **LECTION; RISK ADJUSTMENT PROGRAMS.**

18 (a) **MONITORING.**—The Secretary of Labor shall
19 monitor the prevalence and impact of adverse risk selec-
20 tion in the fully insured plans made available to small em-
21 ployers resulting from the decision of small employers to
22 self insure. State insurance commissioners may submit to
23 the Secretary such information on such adverse risk selec-
24 tion as they determine to be appropriate.

1 (b) RESPONSE.—If the Secretary of Labor deter-
2 mines, on the basis of such information or otherwise, that,
3 due to decisions of small employers to self-insure, there
4 has been substantial or significant favorable selection with
5 respect to self-insured plans or unfavorable selection with
6 respect to fully insured plans in a State, the Secretary
7 shall develop a risk adjustment program under subsection
8 (c) that responds to such a pattern in the State. The Sec-
9 retary shall request the NAIC to submit to the Secretary
10 recommendations regarding the structure and operation of
11 such a program.

12 (c) ESTABLISHMENT OF RISK ADJUSTMENT PRO-
13 GRAM.—The risk adjustment program applied in a State
14 under this subsection—

15 (1) shall be designed to be operated on a non-
16 governmental basis,

17 (2) shall require participation of each small em-
18 ployer in the State that is self-insured,

19 (3) shall require the imposition of such assess-
20 ments on self-insured plans offered by such employ-
21 ers as may be appropriate to prevent further adverse
22 or favorable selection, and

23 (4) shall provide for the distribution of such as-
24 sessments to the State involved for purposes of mak-

ing payments to insurers to stabilize the small group insurance market.

The amounts of the assessments under paragraph (3) for individual employers may take into account the number of lives covered under the plans of such employers and the area of residence of the lives covered.

SEC. 1106. ESTABLISHMENT OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS FOR HIGH RISK INDIVIDUALS IN MARKETPLACE FOR SMALL BUSINESS AND MARKETPLACE FOR INDIVIDUALS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, models for reinsurance or allocation of risk mechanisms (each in this section referred to as a “reinsurance or allocation of risk mechanism”) for health insurance coverage made available to small employers and for whom an insurer is at risk of incurring high costs in providing such coverage. If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for an effective reinsurance or allocation of risk mechanism. Such review shall be completed within 30 days

1 after the date the models are developed. Unless the
2 Secretary determines within such period that such a
3 model is not an effective reinsurance or allocation of
4 risk mechanism, such remaining models shall serve
5 as the models under this section, with such amend-
6 ments as the Secretary deems necessary.

7 (2) CONTINGENCY.—If the NAIC does not de-
8 velop such models within such period or the Sec-
9 retary determines that all such models do not pro-
10 vide for an effective reinsurance or allocation of risk
11 mechanism, the Secretary shall specify, within 15
12 months after the date of the enactment of this Act,
13 models to carry out this section.

14 (b) IMPLEMENTATION OF REINSURANCE OR ALLOCA-
15 TION OF RISK MECHANISMS.—

16 (1) BY STATES.—Each State shall establish
17 and maintain one or more reinsurance or allocation
18 of risk mechanisms that are consistent with a model
19 established under subsection (a) by not later than
20 the deadline specified in section 1103(b)(1)(B). A
21 State may establish and maintain such a mechanism
22 jointly with one or more other States.

23 (2) FEDERAL ROLE.—

24 (A) IN GENERAL.—If the Secretary deter-
25 mines that a State has failed to establish or

1 maintain a reinsurance or allocation of risk
2 mechanism in accordance with paragraph (1),
3 the Secretary shall establish and maintain such
4 a reinsurance or allocation of risk mechanism
5 meeting the requirements of this paragraph.

6 (B) REINSURANCE MECHANISM.—Unless
7 the Secretary determines under subparagraph
8 (C) that an allocation of risk mechanism is the
9 appropriate mechanism to use in a State under
10 this paragraph, the Secretary shall establish
11 and maintain for use under this section for
12 each State an appropriate reinsurance mecha-
13 nism.

14 (C) ALLOCATION OF RISK MECHANISM.—If
15 the Secretary determines that, due to the na-
16 ture of the health coverage market in the State
17 (including a relatively small number of plans of-
18 fered providing health insurance coverage or a
19 relatively small number of uninsurable small
20 employers), an allocation of risk mechanism
21 would be a better mechanism than a reinsur-
22 ance mechanism, the Secretary shall establish
23 and maintain for use under this section for a
24 State an allocation of risk mechanism under
25 which small employers with employees who are

1 at higher risk of significantly higher claims
2 would be equitably assigned among insurers of-
3 fering health insurance coverage to small em-
4 ployers.

5 (c) CONSTRUCTION.—Nothing in this section shall be
6 construed to prohibit reinsurance or allocation of risk ar-
7 rangements relating to health insurance coverage, whether
8 on a State or multi-State basis, not required under this
9 section.

10 **PART 2—MARKETPLACE FOR INDIVIDUALS**

11 **SEC. 1111. APPLICATION OF SIMILAR REQUIREMENTS.**

12 (a) IN GENERAL.—Except as provided in subsection
13 (c)—

14 (1) the provisions of part 1 of this subtitle shall
15 apply to insurers offering health insurance coverage
16 to individuals in the individual market (as defined in
17 subsection (b)) in the same manner as such provi-
18 sions apply to insurers offering health insurance cov-
19 erage to employers, and

20 (2) the standards established under section
21 1103 shall apply under this part in the same manner
22 as they apply under part 1.

23 For purposes of this subsection, any reference to an em-
24 ployee or eligible employee is deemed a reference to such
25 an individual.

1 (b) INDIVIDUAL MARKET DEFINED.—In subsection
 2 (a), the term “individual market” means the insurance
 3 market offered to individuals seeking health care coverage
 4 on behalf of themselves (and their dependents) and not
 5 seeking coverage on the basis of employment, membership
 6 in a organization, or through another group purchasing
 7 arrangement.

8 (c) EXCEPTION AND SPECIAL RULE.—

9 (1) WELLNESS DISCOUNTS.—Section
 10 1104(a)(2) (relating to discounts for employer
 11 wellness programs) shall not apply under this part.

12 (2) SEPARATE APPLICATION OF RISK ADJUST-
 13 MENT TO INDIVIDUAL MARKET SECTOR.—Section
 14 1105 (relating to monitoring and response to ad-
 15 verse selection; risk adjustment programs) shall be
 16 applied under this part in a manner that is separate
 17 from its application under part A.

18 (3) SEPARATE AGE RATING FACTOR FOR THE
 19 INDIVIDUAL MARKET.—The provisions regarding age
 20 under section 1104(a)(1)(A) shall be determined
 21 separately for each year of age and not by the class-
 22 es of age referred to in such section.

23 (4) CONVERSION OF PERMANENT HEALTH IN-
 24 SURANCE POLICIES.—The provisions of section 1104
 25 shall not apply in connection with a permanent pol-

1 iciency of health insurance existing on the effective date,
 2 if each individual covered under the policy is given
 3 the option to convert the policy to a policy of health
 4 insurance subject to this part.

5 (d) APPLICATION OF REQUIREMENTS.—Coverage of-
 6 fered by an insurer shall not be treated as MedAccess cov-
 7 erage under this part unless the insurer complies with the
 8 requirements of part 3 of subtitle A (relating to standards
 9 for managed care arrangements and essential community
 10 providers) in the same manner as such requirements apply
 11 to a group health plan.

12 **PART 3—VOLUNTARY HEALTH PURCHASING**

13 **ARRANGEMENTS**

14 **SEC. 1121. ESTABLISHMENT AND ORGANIZATION.**

15 (a) IN GENERAL.—Voluntary health purchasing ar-
 16 rangements (in this part referred to as “purchasing ar-
 17 rangements”) may be established in accordance with this
 18 part. Each purchasing arrangement shall be chartered
 19 under State law and operated as a not-for-profit corpora-
 20 tion. An insurer may not form, underwrite, or possess a
 21 majority vote of a purchasing arrangement, but may ad-
 22 minister such an arrangement.

23 (b) BOARD OF DIRECTORS.—

24 (1) IN GENERAL.—Each purchasing arrange-
 25 ment shall be governed by a Board of Directors.

Such Board shall initially be appointed under procedures established by the State in which it operates. Subsequently, the Board shall be elected by the members of the arrangement in accordance with paragraph (3). Such Board shall be composed of individuals who are small employers (or representatives of small employers), eligible employees of small employers (or representatives of such employees), and eligible individuals in the area in which the arrangement operates.

(2) MEMBERSHIP.—A purchasing arrangement shall accept all small employers, eligible employees, and eligible individuals residing within the area served by the arrangement as members if such employers, employees or individuals request such membership.

(3) VOTING.—Members of a purchasing arrangement shall have voting rights consistent with the rules established under the bylaws governing the arrangement.

(c) DUTIES OF PURCHASING ARRANGEMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), each purchasing arrangement shall—

1 (A) market MedAccess coverage to mem-
2 bers throughout the entire area served by the
3 arrangement;

4 (B) enter into agreements with insurers of-
5 fering MedAccess coverage under section 1122;

6 (C) enter into agreements with small em-
7 ployers under section 1123;

8 (D) enroll individuals in MedAccess cov-
9 erage, only in accordance with section 1124;
10 and

11 (E) carry out other functions provided for
12 under this part.

13 (2) LIMITATION ON ACTIVITIES.—A purchasing
14 arrangement shall not—

15 (A) perform any activity (including review,
16 approval, or enforcement) relating to payment
17 rates for providers;

18 (B) perform any activity (including certifi-
19 cation or enforcement) relating to compliance of
20 insurers or coverage with the requirements of
21 parts 1 or 2;

22 (C) assume financial risk in relation to any
23 such coverage; or

(D) perform other activities identified by the State as being inconsistent with the performance of its duties under paragraph (1).

(3) CHARACTERISTICS OF SERVICE AREA.—A purchasing arrangement need not serve areas that are contiguous, but the geographic boundaries of such areas shall be consistent with the boundaries established for geographic areas used in establishing premium rates in the individual and small group marketplace. If a purchasing arrangement serves a part of a metropolitan statistical area the arrangement shall serve the entire area.

(d) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

(1) that a purchasing arrangement be established in each area of a State in which it operates; and

(2) that there be only one purchasing arrangement established with respect to any area.

SEC. 1122. AGREEMENTS WITH INSURERS.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (3), each purchasing arrangement for an area shall enter into an agreement under this section with each insurer that desires to make MedAccess cov-

1 erage available through the purchasing arrangement
2 (consistent with any procedures established by the
3 State).

4 (2) TERMINATION OF AGREEMENT.—An agree-
5 ment under paragraph (1) shall remain in effect for
6 a 12-month period, except that the purchasing ar-
7 rangement may terminate an agreement under para-
8 graph (1) if the insurer's license or certification
9 under State law is terminated or for other good
10 cause shown.

11 (3) LIMITATION ON RENEWAL OF AGREE-
12 MENTS.—Subsequent to the 12-month period de-
13 scribed in paragraph (2), a purchasing arrangement
14 may—

15 (A) refuse to enter into a subsequent
16 agreement with an insurer if the arrangement
17 determines that the enrollment or premium is
18 too low, and

19 (B) if a previous agreement with an in-
20 surer was terminated for good cause and the
21 arrangement determines appropriate actions
22 have not been taken to correct the problems,
23 refuse to enter into a subsequent agreement
24 with the insurer.

(4) NO PROHIBITION ON OFFERING OF COVERAGE.—Nothing in this subsection shall be construed as prohibiting an insurer that does not enter into an agreement under paragraph (1) from offering health insurance coverage to small employers and eligible individuals within any area, so long as the premium rates charged outside such arrangement are the same as those charged within the arrangement (subject to reasonable differences in premiums that only reflect savings in administrative costs under such an arrangement).

(b) RECEIPT OF PREMIUMS ON BEHALF OF PLANS.—

(1) IN GENERAL.—Under an agreement under this section between a purchasing arrangement and an insurer—

(A) premiums shall be payable, and

(B) payment of premiums may be made by individuals (or employers on their behalf) directly to the purchasing arrangement for the benefit of the insurer.

(2) TIMING OF PAYMENT OF PREMIUMS.—Premiums may be payable on a monthly basis (or, at the option of an eligible employee or individual, on a quarterly basis). The purchasing arrangement may

1 provide for reasonable penalties and grace periods
2 for late payment.

3 (3) QUALIFIED HEALTH PLANS RETAIN RISK OF
4 NONPAYMENT.—Nothing in this subsection shall be
5 construed as placing upon a purchasing arrangement
6 any risk associated with the failure of individuals
7 and employers to make prompt payment of pre-
8 miums to the purchasing arrangement (other than
9 the portion of the premium representing the pur-
10 chasing arrangement administrative fee under sec-
11 tion 1125). Each small employer and eligible individ-
12 ual who enrolls with an insurer through the purchas-
13 ing arrangement is liable to the insurer for pre-
14 miums.

15 (c) FORWARDING OF PREMIUMS.—

16 (1) IN GENERAL.—If, under an agreement
17 under subsection (a), premium payments for an in-
18 surer are made to the purchasing arrangement, the
19 purchasing arrangement shall forward to the insurer
20 the amount of the premiums and the purchasing ar-
21 rangement (and not the employer or individual) shall
22 be liable for the premium payment collected under
23 such arrangement.

24 (2) PAYMENTS.—Payments shall be made by
25 the purchasing arrangement under this subsection

1 within a period of days (specified by the Secretary
2 and not to exceed 7 days) after receipt of the pre-
3 mium from the small employer of the eligible em-
4 ployee or the eligible individual, as the case may be.

5 **SEC. 1123. PROVISION OF INFORMATION.**

6 (a) **IN GENERAL.**—Each purchasing arrangement for
7 an area shall provide, upon request, to each small em-
8 ployer that employs individuals in the area and to each
9 eligible individual who resides in the area—

10 (1) information provided to the purchasing ar-
11 rangement by the State or insurers in accordance
12 with rules by the State in which such arrangement
13 is located, and

14 (2) the opportunity to enter into an agreement
15 with the arrangement for the purchase of coverage
16 through the insurer.

17 (b) **FORWARDING INFORMATION AND PAYROLL DE-**
18 **DUCTIONS.**—As part of an agreement entered into under
19 this section, a small employer shall forward the informa-
20 tion and make the payroll deductions required under sec-
21 tion 1001.

1 **SEC. 1124. ENROLLING ELIGIBLE EMPLOYEES AND ELIGI-**
2 **BLE INDIVIDUALS THROUGH A PURCHASING**
3 **ARRANGEMENT.**

4 A purchasing arrangement shall offer, on behalf of
5 each insurer with which an agreement was entered into
6 under section 1122 and in accordance with the enrollment
7 procedures of such insurers, enrollment in health insur-
8 ance coverage only to—

9 (1) all eligible employees employed by small em-
10 ployers in the area served by the purchasing ar-
11 rangement; and

12 (2) all eligible individuals residing in such area.

13 **SEC. 1125. RESTRICTION ON CHARGES.**

14 (a) **IN GENERAL.**—A purchasing arrangement may
15 impose an administrative fee with respect to an eligible
16 employee or eligible individual obtaining coverage through
17 the purchasing arrangement.

18 (b) **FEE.**—A purchasing arrangement that elects to
19 impose a fee under subsection (a) shall ensure that such
20 fee is set as a percentage of the premium for such coverage
21 and is imposed uniformly with respect to all coverage pro-
22 vided through the arrangement.

PART 4—DEFINITIONS AND MISCELLANEOUS**PROVISIONS****SEC. 1131. DEFINITIONS.**

Except as otherwise specifically provided, for purposes of this subtitle:

(1) **DEPENDENT CHILD.**—The term “dependent child” means a child (including an adopted child) who is under 19 years of age or who is a full-time student and under 25 years of age.

(2) **ELIGIBLE EMPLOYEE.**—The term “eligible employee” means, with respect to an employer, an employee who—

(A) normally performs on a monthly basis at least 10 hours of service per week for that employer; or

(B) is reasonably expected as of the 1st day of such month to be employed by the employer for a period of 120 consecutive days during any 365-day period that includes such 1st day.

(3) **EMPLOYER.**—The term “employer” shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(4) **HEALTH INSURANCE COVERAGE.**—

1 (A) IN GENERAL.—Except as provided in
2 subparagraph (B), the term “health insurance
3 coverage” means any hospital or medical service
4 policy or certificate, hospital or medical service
5 plan contract, or health maintenance organiza-
6 tion group contract offered by an insurer.

7 (B) EXCEPTION.—Such term does not in-
8 clude any of the following:

9 (i) Coverage only for accident, dental,
10 vision, disability income, or long-term care
11 insurance, or any combination thereof.

12 (ii) Medicare supplemental health in-
13 surance.

14 (iii) Coverage issued as a supplement
15 to liability insurance.

16 (iv) Liability insurance, including gen-
17 eral liability insurance and automobile li-
18 ability insurance.

19 (v) Worker’s compensation or similar
20 insurance.

21 (vi) Automobile medical-payment in-
22 surance.

23 (vii) Coverage for a specified disease
24 or illness.

(viii) A hospital or fixed indemnity policy.

(5) NETWORK PLAN.—The term “network plan” includes, as defined in standards established under section 1103, an organization that provides health insurance coverage which meets specified standards and under which health services are offered to be provided on a prepaid, at-risk basis primarily through a defined set of providers.

(6) INSURER.—The term “insurer” means a licensed insurance company, an entity offering prepaid hospital or medical services, and a health maintenance organization offering such services to an employer, and includes a similar organization regulated under State law for solvency.

(7) NAIC.—The term “NAIC” means the National Association of Insurance Commissioners.

(8) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(9) SMALL EMPLOYER.—The term “small employer” means, with respect to a calendar year, an employer that normally employs more than 1 but less than 51 eligible employees on a typical business day. For the purposes of this paragraph, the term “employee” includes a self-employed individual. For

1 purposes of determining if an employer is a small
2 employer, rules similar to the rules of subsection (b)
3 and (c) of section 414 of the Internal Revenue Code
4 of 1986 shall apply.

5 (10) STATE.—The term “State” means the 50
6 States, the District of Columbia, Puerto Rico, the
7 Virgin Islands, Guam, and American Samoa.

8 (11) STATE COMMISSIONER OF INSURANCE.—
9 The term “State commissioner of insurance” in-
10 cludes a State superintendent of insurance.

11 **SEC. 1132. ENFORCEMENT.**

12 For enforcement of requirements of this subtitle, see
13 section 1031.

14 **SEC. 1133. PROHIBITION OF IMPROPER INCENTIVES.**

15 (a) LIMITATION ON FINANCIAL INCENTIVES.—No in-
16 surer that offers health insurance coverage may vary the
17 commission or financial or other remuneration to a person
18 based on the claims experience or health status of individ-
19 uals enrolled by or through the person.

20 (b) PROHIBITION OF TIE-IN ARRANGEMENTS.—No
21 insurer that offers health insurance coverage may require
22 the purchase of any other insurance or product as a condi-
23 tion for the purchase of such coverage.

1 **SEC. 1134. ANNUAL REPORTS.**

2 (a) IN GENERAL.—The Secretary shall submit to
3 Congress an annual report on the implementation of this
4 subtitle and the need for additional reforms to assure and
5 expand coverage.

6 (b) INFORMATION REGARDING IMPACT OF RE-
7 FORMS.—Each annual report shall include information
8 concerning at least the following:

9 (1) Implementation and enforcement of the ap-
10 plicable MedAccess standards and consumer protec-
11 tion standards under this subtitle by the States and
12 by the Secretary.

13 (2) An evaluation of the impact of the reforms
14 under this subtitle on the availability of affordable
15 health coverage for individuals and for small employ-
16 ers that purchase group health coverage and for
17 their employees, and, in particular, the impact of—

18 (A) guaranteed availability of health cov-
19 erage,

20 (B) limitations of restrictions from cov-
21 erage of preexisting conditions,

22 (C) requirement for continuity of coverage,

23 (D) risk-management mechanisms for
24 health coverage,

25 (E) limits on premium variations, and

26 (F) preemption of State benefit mandates.

1 In performing such evaluation, the Secretary shall
2 seek to discount the effect of the insurance cycle on
3 health insurance premiums.

4 (3) An assessment of the implications of the re-
5 forms on adverse selection among health insurance
6 plans and the distribution of risk among health in-
7 surance plans.

8 (c) INFORMATION REGARDING COVERAGE OF THE
9 UNINSURED.—The report submitted under this section 5
10 years after the date of the enactment of this Act also shall
11 include findings and recommendations regarding each of
12 the following:

13 (1) Characteristics of the insured and unin-
14 sured, including demographic characteristics, work-
15 ing status, health status, and geographic distribu-
16 tion.

17 (2) Steps which should be taken to improve ac-
18 cess to health care and increase health insurance
19 coverage of the chronically uninsured.

20 (3) Effectiveness of efforts to measure and im-
21 prove health care outcomes in the public and private
22 sectors.

23 (4) Effectiveness of initiatives targeted to im-
24 proving access of underserved urban and rural popu-
25 lations to health care services.

(5) Effectiveness of new Federal subsidy programs, including recommendations to restrain future growth of such programs.

**SEC. 1135. RESEARCH AND DEMONSTRATION PROJECTS;
DEVELOPMENT OF A HEALTH RISK POOLING
MODEL.**

(a) RESEARCH AND DEMONSTRATIONS.—The Secretary is authorized, directly, by contract, and through grants and cooperative agreements within the Department of Health and Human Services and outside the Department—

(1) to conduct research on the impact of this subtitle on the availability of affordable health coverage for employees and dependents in the small employers group and individual health care coverage market and other topics described in section 1134(b), and

(2) to conduct demonstration projects relating to such topics.

**(b) DEVELOPMENT OF METHODS OF MEASURING
RELATIVE HEALTH RISK.—**

(1) IN GENERAL.—The Secretary shall develop methods for measuring, in terms of the expected costs of providing benefits under health insurance

1 plans and, in particular, MedAccess plans, the rel-
2 ative health risks of eligible individuals.

3 (2) METHODOLOGY.—The methods—

4 (A) shall rely on diagnosis or other health-
5 related information that is predictive of individ-
6 ual health care needs,

7 (B) may rely upon information routinely
8 collected in the process of making payments
9 under group health plans, and

10 (C) may provide for such random, sample
11 audits of records as may be necessary to verify
12 the accuracy of measurements.

13 (c) DEVELOPMENT OF A HEALTH RISK POOLING
14 MODEL.—

15 (1) IN GENERAL.—The Secretary shall develop
16 a model, based on the methods of measuring risks
17 under subsection (b), for equitably distributing
18 health risks among insurers and group health plans
19 in the small employer and individual health care cov-
20 erage market.

21 (2) REDISTRIBUTION OF RISK.—Under such
22 model, insurers and group health plans with below
23 average health risks would be required to contribute
24 to a common fund for payment to insurers and
25 group health plans with above average health risks,

each in relation to the degree of their favorable or adverse risk selection.

(3) INCENTIVES.—Such model shall include incentives to encourage continuous coverage of individuals and eligible individuals and small employers.

(d) CONSULTATION.—The methods and model under this section shall be developed in consultation with the NAIC.

(e) REPORT.—By not later than January 1, 1996, the Secretary shall submit to Congress a report on the methods and model developed under this section (as well as on research and demonstration projects conducted under subsection (a)). The Secretary shall include in the report such recommendations respecting the application of the model to insurers and group health plans (and, in particular, to MedAccess plans) under this subtitle as the Secretary deems appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, \$5,000,000 in each of fiscal years 1995 through 1999.

Subtitle C—Preemption

PART 1—SCOPE OF STATE REGULATION

SEC. 1201. PROHIBITION OF STATE BENEFIT MANDATES FOR GROUP HEALTH PLANS.

In the case of a group health plan, no provision of State or local law shall apply that requires the coverage of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care.

SEC. 1202. PROHIBITION OF PROVISIONS PROHIBITING EM- PLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage under a multiple employer welfare arrangement under which all coverage consists of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 and is fully insured.

SEC. 1203. PREEMPTION OF STATE ANTI-MANAGED CARE LAWS.

(a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES
OR SELECTIVE CONTRACTING.—Any law that re-

1 stricts the ability of a group health plan or insurer
2 to negotiate reimbursement rates with providers or
3 to contract selectively with one provider or a limited
4 number of providers.

5 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
6 CIAL INCENTIVES.—Any law that limits the financial
7 incentives that a group health plan or insurer may
8 require a beneficiary to pay when a non-plan pro-
9 vider is used on a non-emergency basis.

10 (3) RESTRICTIONS ON UTILIZATION REVIEW
11 METHODS.—Any law that—

12 (A) prohibits utilization review of any or
13 all treatments and conditions,

14 (B) requires that such review be made (i)
15 by a resident of the State in which the treat-
16 ment is to be offered or by an individual li-
17 censed in such State, or (ii) by a physician in
18 any particular specialty or with any board cer-
19 tified specialty of the same medical specialty as
20 the provider whose services are being reviewed,

21 (C) requires the use of specified standards
22 of health care practice in such reviews or re-
23 quires the disclosure of the specific criteria used
24 in such reviews,

1 (D) requires payments to providers for the
2 expenses of responding to utilization review re-
3 quests,

4 (E) imposes liability for delays in perform-
5 ing such review, or

6 (F) requires standards in addition to or in-
7 consistent with standards established under sec-
8 tion 1022(b).

9 Nothing in subparagraph (B) shall be construed as
10 prohibiting a State from (i) requiring a licensed phy-
11 sician or other health care professional be available
12 at some time in the review or appeal process, or (ii)
13 requiring that any decision in an appeal from such
14 a review be made by a licensed physician.

15 (b) GAO STUDY.—

16 (1) IN GENERAL.—The Comptroller General
17 shall conduct a study of the benefits and cost effec-
18 tiveness of the use of managed care in the delivery
19 of health services.

20 (2) REPORT.—By not later than 4 years after
21 the date of the enactment of this Act, the Comptrol-
22 ler General shall submit a report to Congress on the
23 study conducted under paragraph (1) and shall in-
24 clude in the report such recommendations (including

1 whether the provisions of subsection (a) should be
2 extended) as may be appropriate.

3 (c) SUNSET.—Unless otherwise provided, subsection
4 (a) shall not apply 5 years after the date of the enactment
5 of this Act.

6 **SEC. 1204. DEFINITIONS.**

7 For purposes of this part, the terms “dependent”,
8 “employee”, “employer”, “fully insured”, “group health
9 plan”, “health insurance plan”, “multiple employer wel-
10 fare arrangement”, and “State” have the meanings given
11 such terms in section 1023(a).

12 **PART 2—MULTIPLE EMPLOYER HEALTH**
13 **BENEFITS PROTECTIONS**

14 **SEC. 1211. LIMITED EXEMPTION FROM CERTAIN RESTRIC-**
15 **TIONS ON ERISA PREEMPTION OF STATE LAW**
16 **FOR HEALTH PLANS MAINTAINED BY MUL-**
17 **TIPLE EMPLOYERS SUBJECT TO CERTAIN**
18 **FEDERAL STANDARDS.**

19 (a) IN GENERAL.—Subtitle B of title I of the Em-
20 ployee Retirement Income Security Act of 1974 is amend-
21 ed by adding at the end the following new part:

22 “Part 7—Multiple Employer Health Plans

23 **“SEC. 701. DEFINITIONS.**

24 “For purposes of this part—

1 “(1) INSURER.—The term ‘insurer’ means an
2 insurance company, insurance service, or insurance
3 organization, licensed to engage in the business of
4 insurance by a State.

5 “(2) PARTICIPATING EMPLOYER.—The term
6 ‘participating employer’ means, in connection with a
7 multiple employer welfare arrangement, any em-
8 ployer if any of its employees, or any of the depend-
9 ents of its employees, are or were covered under
10 such arrangement in connection with the employ-
11 ment of the employees.

12 “(3) EXCESS/STOP LOSS COVERAGE.—The term
13 ‘excess/stop loss coverage’ means, in connection with
14 a multiple employer welfare arrangement, a contract
15 under which an insurer provides for payment with
16 respect to claims under the arrangement, relating to
17 participants or beneficiaries individually or other-
18 wise, in excess of an amount or amounts specified in
19 such contract.

20 “(4) QUALIFIED ACTUARY.—The term ‘quali-
21 fied actuary’ means an individual who is a member
22 of the American Academy of Actuaries or meets
23 such reasonable standards and qualifications as the
24 Secretary may provide by regulation.

1 “(5) SPONSOR.—The term ‘sponsor’ means, in
2 connection with a multiple employer welfare arrange-
3 ment, the association or other entity which estab-
4 lishes or maintains the arrangement.

5 “(6) STATE INSURANCE COMMISSIONER.—The
6 term ‘State insurance commissioner’ means the in-
7 surance commissioner (or similar official) of a State.

8 “(7) DOMICILE STATE.—The term ‘domicile
9 State’ means, in connection with a multiple employer
10 welfare arrangement, the State in which, according
11 to the application for an exemption under this part,
12 most individuals to be covered under the arrange-
13 ment are located, except that, in any case in which
14 information contained in the latest annual report of
15 the arrangement filed under this part indicates that
16 most individuals covered under the arrangement are
17 located in a different State, such term means such
18 different State.

19 “(8) FULLY INSURED.—Coverage under a mul-
20 tiple employer welfare arrangement is ‘fully insured’
21 if one or more insurers, health maintenance organi-
22 zations, similar organizations regulated under State
23 law for solvency, or any combination thereof are lia-
24 ble under one or more insurance policies or contracts
25 for all benefits under the arrangement (irrespective

1 of any recourse they may have against other par-
 2 ties).

3 “(9) EXEMPTED MULTIPLE EMPLOYER HEALTH
 4 PLAN.—The term ‘exempted multiple employer
 5 health plan’ means a multiple employer welfare ar-
 6 rangement treated as an employee welfare benefit
 7 plan by reason of an exemption under this part.

8 “(10) COMMUNITY HEALTH NETWORK.—The
 9 term ‘community health network’ has the meaning
 10 given such term in section 1421 of the Affordable
 11 Health Care Now Act of 1994.

12 **“SEC. 702. EXEMPTED MULTIPLE EMPLOYER HEALTH**
 13 **PLANS RELIEVED OF CERTAIN RESTRIC-**
 14 **TIONS ON PREEMPTION OF STATE LAW AND**
 15 **TREATED AS EMPLOYEE WELFARE BENEFIT**
 16 **PLANS.**

17 “(a) IN GENERAL.—Subject to subsection (b), a mul-
 18 tiple employer welfare arrangement under which coverage
 19 is not fully insured and with respect to which there is in
 20 effect an exemption granted by the Secretary under this
 21 part (or with respect to which there is pending a complete
 22 application for such an exemption and the Secretary deter-
 23 mines that provisional protection under this part is appro-
 24 priate)—

1 “(1) shall be treated for purposes of subtitle A
2 and the preceding parts of this subtitle as an em-
3 ployee welfare benefit plan, irrespective of whether
4 such arrangement is an employee welfare benefit
5 plan, and

6 “(2) shall be exempt from section
7 514(b)(6)(A)(ii).

8 “(b) BENEFITS MUST CONSIST OF MEDICAL
9 CARE.—Subsection (a) shall apply to a multiple employer
10 welfare arrangement only if the benefits provided there-
11 under consist solely of medical care described in section
12 607(1) (disregarding such incidental benefits as the
13 Secretary shall specify by regulation).

14 “(c) RESTRICTION ON COMMENCEMENT OF NEW AR-
15 RANGEMENTS.—A multiple employer welfare arrangement
16 providing benefits which consist of medical care described
17 in section 607(1) which has not commenced operations as
18 of January 1, 1995, may commence operations only if an
19 exemption granted to the arrangement under this part is
20 in effect (or there is pending with respect to the arrange-
21 ment a complete application for such an exemption and
22 the Secretary determines that provisional protection under
23 this part is appropriate).

1 **“SEC. 703. EXEMPTION PROCEDURE.**

2 “(a) IN GENERAL.—The Secretary shall grant an ex-
3 emption described in section 702(a) to a multiple employer
4 welfare arrangement if—

5 “(1) an application for such exemption with re-
6 spect to such arrangement, identified individually or
7 by class, has been duly filed in complete form with
8 the Secretary in accordance with this part,

9 “(2) such application demonstrates compliance
10 with the requirements of section 704 with respect to
11 such arrangement, and

12 “(3) the Secretary finds that such exemption
13 is—

14 “(A) administratively feasible,

15 “(B) not adverse to the interests of the in-
16 dividuals covered under the arrangement, and

17 “(C) protective of the rights and benefits
18 of the individuals covered under the arrange-
19 ment.

20 “(b) NOTICE AND HEARING.—Before granting an ex-
21 emption under this section, the Secretary shall publish no-
22 tice in the Federal Register of the pendency of the exemp-
23 tion, shall require that adequate notice be given to inter-
24 ested persons, including the State insurance commissioner
25 of each State in which covered individuals under the ar-
26 rangement are, or are expected to be, located, and shall

1 afford interested persons opportunity to present views.
2 The Secretary may not grant an exemption under this sec-
3 tion unless the Secretary affords an opportunity for a
4 hearing and makes a determination on the record with re-
5 spect to the findings required under subsection (a)(3). The
6 Secretary shall, to the maximum extent practicable, make
7 a final determination with respect to any application filed
8 under this section in the case of a newly established ar-
9 rangement within 90 days after the date which the Sec-
10 retary determines is the date on which such application
11 is filed in complete form.

12 **“SEC. 704. ELIGIBILITY REQUIREMENTS.**

13 “(a) APPLICATION FOR EXEMPTION.—

14 “(1) IN GENERAL.—An exemption may be
15 granted by the Secretary under this part only on the
16 basis of an application filed with the Secretary in
17 such form and manner as shall be prescribed in reg-
18 ulations of the Secretary. Any such application shall
19 be signed by the operating committee and the spon-
20 sor of the arrangement.

21 “(2) FILING FEE.—The arrangement shall pay
22 to the Secretary at the time of filing an application
23 under this section a filing fee in the amount of
24 \$5,000, which shall be available, to the extent pro-
25 vided in appropriation Acts, to the Secretary for the

1 sole purpose of administering the exemption proce-
2 dures under this part.

3 “(3) INFORMATION INCLUDED.—An application
4 filed under this section shall include, in a manner
5 and form prescribed in regulations of the Secretary,
6 at least the following information:

7 “(A) IDENTIFYING INFORMATION.—The
8 names and addresses of—

9 “(i) the sponsor, and

10 “(ii) the members of the operating
11 committee of the arrangement.

12 “(B) STATES IN WHICH ARRANGEMENT IN-
13 TENDS TO DO BUSINESS.—The States in which
14 individuals covered under the arrangement are
15 to be located and the number of such individ-
16 uals expected to be located in each such State.

17 “(C) BONDING REQUIREMENTS.—Evidence
18 provided by the operating committee that the
19 bonding requirements of section 412 will be met
20 as of the date of the application.

21 “(D) PLAN DOCUMENTS.—A copy of the
22 documents governing the arrangement (includ-
23 ing any bylaws and trust agreements), the sum-
24 mary plan description, and other material de-
25 scribing the benefits and coverage that will be

provided to individuals covered under the arrangement.

“(E) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the arrangement and contract administrators and other service providers.

“(F) FUNDING REPORT.—A report setting forth information determined as of a date within the 120-day period ending with the date of the application, including the following:

“(i) RESERVES.—A statement, certified by the operating committee of the arrangement, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 707 are or will be met in accordance with regulations which the Secretary shall prescribe.

“(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period be-

ginning with such date within such 120-day period, taking into account the expected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

“(iii) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the 12-month period referred to in clause (ii). The income statement shall identify separately the arrangement’s administrative expenses and claims.

“(iv) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and

other expenses associated with the operation of the arrangement.

“(v) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

“(b) OTHER REQUIREMENTS.—A complete application for an exemption under this part shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

“(1) SPONSOR.—

“(A) IN GENERAL.—Except in a case to which subparagraph (B) or (C) applies, the sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care

1 described in section 607(1), and the applicant
2 demonstrates to the satisfaction of the Sec-
3 retary that the sponsor is established as a per-
4 manent entity which receives the active support
5 of its members.

6 “(B) SPECIAL RULE FOR COMMUNITY
7 HEALTH NETWORKS.—In the case of an ar-
8 rangement that is a community health network
9 (as defined in section 701(11)), the sponsor is
10 the operating committee of the network.

11 “(C) SPECIAL RULE FOR EMPLOYERS IN
12 THE SAME TRADE OR BUSINESS.—In the case
13 of an arrangement under which all participating
14 employers are engaged in a common type of
15 trade or business, the sponsor is the operating
16 committee of the arrangement.

17 “(2) OPERATING COMMITTEE.—

18 “(A) IN GENERAL.—Except as provided in
19 subparagraph (B), the arrangement is operated,
20 pursuant to a trust agreement, by an operating
21 committee which has complete fiscal control
22 over the arrangement and which is responsible
23 for all operations of the arrangement, and the
24 operating committee has in effect rules of oper-
25 ation and financial controls, based on a 3-year

1 plan of operation, adequate to carry out the
2 terms of the arrangement and to meet all re-
3 quirements of this title applicable to the ar-
4 rangement. The members of the committee are
5 individuals selected from individuals who are
6 the owners, officers, directors, or employees of
7 the participating employers or who are partners
8 in the participating employers and actively par-
9 ticipate in the business. No such member is an
10 owner, officer, director, or employee of, or part-
11 ner in, a contract administrator or other service
12 provider to the arrangement, except that offi-
13 cers or employees of a sponsor which is a serv-
14 ice provider (other than a contract adminis-
15 trator) to the arrangement may be members of
16 the committee if they constitute not more than
17 25 percent of the membership of the committee
18 and they do not provide services to the arrange-
19 ment other than on behalf of the sponsor. The
20 committee has sole authority to approve appli-
21 cations for participation in the arrangement
22 and to contract with a service provider to ad-
23 minister the day-to-day affairs of the arrange-
24 ment.

1 “(B) SPECIAL RULE FOR COMMUNITY
2 HEALTH NETWORKS.—In the case of an ar-
3 rangement that is a community health network
4 (as defined in section 701(11)), the operating
5 committee is the board of the entity that is the
6 network.

7 “(3) CONTENTS OF GOVERNING INSTRU-
8 MENTS.—The instruments governing the arrange-
9 ment include a written instrument, meeting the re-
10 quirements of an instrument required under section
11 1212(a)(1), which—

12 “(A) provides that the committee serves as
13 the named fiduciary required for plans under
14 section 1212(a)(1) and serves in the capacity of
15 a plan administrator (referred to in section
16 3(16)(A)),

17 “(B) provides that the sponsor is to serve
18 as plan sponsor (referred to in section
19 3(16)(B)),

20 “(C) incorporates the requirements of sec-
21 tion 707, and

22 “(D) provides that, effective upon the
23 granting of an exemption under this part—

24 “(i) all participating employers must
25 be members or affiliated members of the

1 sponsor, except that, in the case of a spon-
 2 sor which is a professional association or
 3 other individual-based association, if at
 4 least one of the officers, directors, or em-
 5 ployees of an employer, or at least one of
 6 the individuals who are partners in an em-
 7 ployer and who actively participates in the
 8 business, is a member or affiliated member
 9 of the sponsor, participating employers
 10 may also include such employer, and

11 “(ii) all individuals thereafter com-
 12 mencing coverage under the arrangement
 13 must be—

14 “(I) active or retired owners, offi-
 15 cers, directors, or employees of, or
 16 partners in, participating employers,
 17 or

18 “(II) the beneficiaries of individ-
 19 uals described in subclause (I).

20 “(4) CONTRIBUTION RATES.—The contribution
 21 rates referred to in subsection (a)(3)(F)(ii) are
 22 adequate.

23 “(5) REGULATORY REQUIREMENTS.—Such
 24 other requirements as the Secretary may prescribe

1 by regulation as necessary to carry out the purposes
2 of this part.

3 “(c) TREATMENT OF PARTY SEEKING EXEMPTION
4 WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

5 “(1) IN GENERAL.—In the case of any applica-
6 tion for an exemption under this part with respect
7 to a multiple employer welfare arrangement, if the
8 Secretary determines that the sponsor of the ar-
9 rangement or any other person associated with the
10 arrangement is subject to disqualification under
11 paragraph (2), the Secretary may deny the exemp-
12 tion with respect to such arrangement.

13 “(2) DISQUALIFICATION.—A person is subject
14 to disqualification under this paragraph if such per-
15 son—

16 “(A) has intentionally made a material
17 misstatement in the application for exemption;

18 “(B) has obtained or attempted to obtain
19 an exemption under this part through misrepre-
20 sentation or fraud;

21 “(C) has misappropriated or converted to
22 such person’s own use, or improperly withheld,
23 money held under a plan or any multiple
24 employer welfare arrangement;

1 “(D) is prohibited (or would be prohibited
2 if the arrangement were a plan) from serving in
3 any capacity in connection with the arrange-
4 ment under section 411,

5 “(E) has failed to appear without reason-
6 able cause or excuse in response to a subpoena,
7 examination, warrant, or any other order law-
8 fully issued by the Secretary compelling such
9 response,

10 “(F) has previously been subject to a de-
11 termination under this part resulting in the de-
12 nial, suspension, or revocation of an exemption
13 under this part on similar grounds, or

14 “(G) has otherwise violated any provision
15 of this title with respect to a matter which the
16 Secretary determines of sufficient consequence
17 to merit disqualification for purposes of this
18 part.

19 “(d) FRANCHISE NETWORKS.—In the case of a mul-
20 tiple employer welfare arrangement established and main-
21 tained by a franchisor for a franchise network consisting
22 of its franchisees, such franchisor shall be treated as the
23 sponsor referred to in the preceding provisions of this sec-
24 tion, such network shall be treated as an association re-
25 ferred to in such provisions, and each franchisee shall be

1 treated as a member (of the association and the sponsor)
2 referred to in such provisions, if all participating employ-
3 ers are such franchisees and the requirements of sub-
4 section (b)(1) with respect to a sponsor are met with
5 respect to the network.

6 “(e) CERTAIN COLLECTIVELY BARGAINED ARRANGE-
7 MENTS.—In applying the preceding provisions of this sec-
8 tion in the case of a multiple employer welfare arrange-
9 ment which would be described in section 3(40)(A)(i) but
10 for the failure to meet any requirement of section
11 3(40)(C)—

12 “(1) paragraphs (1) and (2) of subsection (b)
13 and subparagraphs (A), (B), and (D) of paragraph
14 (3) of subsection (b) shall be disregarded, and

15 “(2) the joint board of trustees shall be consid-
16 ered the operating committee of the arrangement.

17 “(f) CERTAIN ARRANGEMENTS NOT MEETING SIN-
18 GLE EMPLOYER REQUIREMENT.—

19 “(1) IN GENERAL.—In any case in which the
20 majority of the employees covered under a multiple
21 employer welfare arrangement are employees of a
22 single employer (within the meaning of clauses (i)
23 and (ii) of section 3(40)(B)), if all other employees
24 covered under the arrangement are employed by em-

1 ployers who are related to such single employer, sub-
2 section (b)(3)(D) shall be disregarded.

3 “(2) RELATED EMPLOYERS.—For purposes of
4 paragraph (1), employers are ‘related’ if there is
5 among all such employers a common ownership in-
6 terest or a substantial commonality of business oper-
7 ations based on common suppliers or customers.

8 **“SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO**
9 **EXEMPTED MULTIPLE EMPLOYER HEALTH**
10 **PLANS.**

11 “(a) NOTICE OF MATERIAL CHANGES.—In the case
12 of any exempted multiple employer health plan, descrip-
13 tions of material changes in any information which was
14 required to be submitted with the application for the ex-
15 emption granted under this part shall be filed in such form
16 and manner as shall be prescribed in regulations of the
17 Secretary. The Secretary may require by regulation prior
18 notice of material changes with respect to specified mat-
19 ters which might serve as the basis for suspension or rev-
20 ocation of the exemption.

21 “(b) REPORTING REQUIREMENTS.—Under regula-
22 tions of the Secretary, the requirements of sections 102,
23 103, and 104 shall apply with respect to any multiple em-
24 ployer welfare arrangement which is or has been an ex-
25 empted multiple employer health plan in the same manner

1 and to the same extent as such requirements apply to em-
2 ployee welfare benefit plans, irrespective of whether such
3 exemption continues in effect. The annual report required
4 under section 103 for any plan year in the case of any
5 such multiple employer welfare arrangement shall also in-
6 clude information described in section 704(a)(3)(F) with
7 respect to the plan year and, notwithstanding section
8 104(a)(1)(A), shall be filed not later than 90 days after
9 the close of the plan year.

10 “(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The
11 operating committee of each multiple employer welfare ar-
12 rangement which is or has been an exempted multiple em-
13 ployer health plan shall engage, on behalf of all covered
14 individuals, a qualified actuary who shall be responsible
15 for the preparation of the materials comprising informa-
16 tion necessary to be submitted by a qualified actuary
17 under this part. The qualified actuary shall utilize such
18 assumptions and techniques as are necessary to enable
19 such actuary to form an opinion as to whether the con-
20 tents of the matters reported under this part—

21 “(1) are in the aggregate reasonably related to
22 the experience of the arrangement and to reasonable
23 expectations, and

24 “(2) represent such actuary’s best estimate of
25 anticipated experience under the arrangement.

1 The opinion by the qualified actuary shall be made with
2 respect to, and shall be made a part of, the annual report.

3 “(d) FILING NOTICE OF EXEMPTION WITH
4 STATES.—An exemption granted to a multiple employer
5 welfare arrangement under this part shall not be effective
6 unless written notice of such exemption is filed with the
7 State insurance commissioner of each State in which at
8 least 5 percent of the individuals covered under the ar-
9 rangement are located. For purposes of this paragraph,
10 an individual shall be considered to be located in the State
11 in which a known address of such individual is located or
12 in which such individual is employed. The Secretary may
13 by regulation provide in specified cases for the application
14 of the preceding sentence with lesser percentages in lieu
15 of such 5 percent amount.

16 **“SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY**
17 **ARRANGEMENTS PROVIDING MEDICAL CARE.**

18 “(a) IN GENERAL.—A multiple employer welfare ar-
19 rangement providing benefits consisting of medical care
20 described in section 607(1) shall issue to each participat-
21 ing employer—

22 “(1) a document equivalent to the summary
23 plan description required of plans under part 1,

24 “(2) information describing the contribution
25 rates applicable to participating employers, and

1 “(3) a statement indicating—

2 “(A) that the arrangement is not a li-
3 censed insurer under the laws of any State,

4 “(B) whether coverage under the arrange-
5 ment is fully insured,

6 “(C) if coverage under the arrangement if
7 not fully insured, (i) whether the arrangement
8 is (or has ceased to be) an exempted multiple
9 employer health plan, and (ii) if such an ar-
10 rangement is an exempted multiple employer
11 health plan, that such arrangement is treated
12 as an employee welfare benefit plan under this
13 title.

14 “(b) TIME FOR DISCLOSURE.—Such information
15 shall be issued to employers within such reasonable period
16 of time before becoming participating employers as may
17 be prescribed in regulations of the Secretary.

18 **“SEC. 707. MAINTENANCE OF RESERVES.**

19 “(a) IN GENERAL.—Each multiple employer welfare
20 arrangement which is or has been an exempted multiple
21 employer health plan and under which coverage is not fully
22 insured shall establish and maintain reserves, consisting
23 of—

24 “(1) a reserve for unearned contributions,

1 “(2) a reserve for payment of claims reported
2 and not yet paid and claims incurred but not yet re-
3 ported, and for expected administrative costs with
4 respect to such claims, and

5 “(3) a reserve, in an amount recommended by
6 the qualified actuary, for any other obligations of
7 the arrangement.

8 “(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—

9 The total of the reserves described in subsection (a)(2)
10 shall not be less than an amount equal to 25 percent of
11 expected incurred claims and expenses for the plan year.

12 “(c) REQUIRED MARGIN.—In determining the
13 amounts of reserves required under this section in connec-
14 tion with any multiple employer welfare arrangement, the
15 qualified actuary shall include a margin for error and
16 other fluctuations taking into account the specific
17 circumstances of such arrangement.

18 “(d) ADDITIONAL REQUIREMENTS.—The Secretary
19 may provide such additional requirements relating to re-
20 serves and excess/stop loss coverage as the Secretary con-
21 siders appropriate. Such requirements may be provided,
22 by regulation or otherwise, with respect to any arrange-
23 ment or any class of arrangements.

24 “(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COV-
25 ERAGE.—The Secretary may provide for adjustments to

1 the levels of reserves otherwise required under subsections
2 (a) and (b) with respect to any arrangement or class of
3 arrangements to take into account excess/stop loss cov-
4 erage provided with respect to such arrangement or ar-
5 rangements.

6 “(f) ALTERNATIVE MEANS OF COMPLIANCE.—The
7 Secretary may permit an arrangement (including a com-
8 munity health network) to substitute, for all or part of
9 the reserves required under subsection (a), such security,
10 guarantee, or other financial arrangement as the Sec-
11 retary determines to be adequate to enable the arrange-
12 ment to fully meet all its financial obligations on a timely
13 basis.

14 **“SEC. 708. CORRECTIVE ACTIONS.**

15 “(a) ACTIONS TO AVOID DEPLETION OF RE-
16 SERVES.—A multiple employer welfare arrangement with
17 respect to which there is or has been in effect an exemp-
18 tion granted under this part shall continue to meet the
19 requirements of section 707, irrespective of whether such
20 exemption continues in effect. The operating committee of
21 such arrangement shall determine semiannually whether
22 the requirements of section 707 are met. In any case in
23 which the committee determines that there is reason to
24 believe that there is or will be a failure to meet such re-
25 quirements, or the Secretary makes such a determination

1 and so notifies the committee, the committee shall imme-
2 diately notify the qualified actuary engaged by the ar-
3 rangement, and such actuary shall, not later than the end
4 of the next following month, make such recommendations
5 to the committee for corrective action as the actuary deter-
6 mines necessary to ensure compliance with section 707.
7 Not later than 10 days after receiving from the actuary
8 recommendations for corrective actions, the committee
9 shall notify the Secretary (in such form and manner as
10 the Secretary may prescribe by regulation) of such rec-
11 ommendations of the actuary for corrective action, to-
12 gether with a description of the actions (if any) that the
13 committee has taken or plans to take in response to such
14 recommendations. The committee shall thereafter report
15 to the Secretary, in such form and frequency as the Sec-
16 retary may specify to the committee, regarding corrective
17 action taken by the committee until the requirements of
18 section 707 are met.

19 “(b) TERMINATION.—

20 “(1) NOTICE OF TERMINATION.—In any case in
21 which the operating committee of a multiple em-
22 ployer welfare arrangement which is or has been an
23 exempted multiple employer health plan determines
24 that there is reason to believe that the arrangement
25 will terminate, the committee shall so inform the

1 Secretary, shall develop a plan for winding up the
2 affairs of the arrangement in connection with such
3 termination in a manner which will result in timely
4 payment of all benefits for which the arrangement is
5 obligated, and shall submit such plan in writing to
6 the Secretary. Actions required under this paragraph
7 shall be taken in such form and manner as may be
8 prescribed in regulations of the Secretary.

9 “(2) ACTIONS REQUIRED IN CONNECTION WITH
10 TERMINATION.—In any case in which—

11 “(A) the Secretary has been notified under
12 subsection (a) of a failure of a multiple em-
13 ployer welfare arrangement which is or has
14 been an exempted multiple employer health plan
15 to meet the requirements of section 707 and
16 has not been notified by the operating commit-
17 tee of the arrangement that corrective action
18 has restored compliance with such require-
19 ments, and

20 “(B) the Secretary determines that the
21 continuing failure to meet the requirements of
22 section 707 can be reasonably expected to result
23 in a continuing failure to pay benefits for which
24 the arrangement is obligated,

1 the operating committee of the arrangement shall, at
2 the direction of the Secretary, terminate the ar-
3 rangement and, in the course of the termination,
4 take such actions as the Secretary may require as
5 necessary to ensure that the affairs of the arrange-
6 ment will be, to the maximum extent possible, wound
7 up in a manner which will result in timely payment
8 of all benefits for which the arrangement is
9 obligated.

10 **“SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF**
11 **EXEMPTION.**

12 **“(a) EXPIRATION AND RENEWAL OF EXEMPTION.—**

13 An exemption granted to a multiple employer welfare ar-
14 rangement under this part shall expire 3 years after the
15 date on which the exemption is granted. An exemption
16 which has expired may be renewed by means of application
17 for an exemption in accordance with section 704.

18 **“(b) SUSPENSION OR REVOCATION OF EXEMPTION**
19 **BY SECRETARY.—**The Secretary may suspend or revoke
20 an exemption granted to a multiple employer welfare
21 arrangement under this part—

22 **“(1) for any cause that may serve as the basis**
23 **for the denial of an initial application for such an**
24 **exemption under section 704, or**

25 **“(2) if the Secretary finds that—**

1 “(A) the arrangement, or the sponsor
2 thereof, in the transaction of business while
3 under the exemption, has used fraudulent, coer-
4 cive, or dishonest practices, or has dem-
5 onstrated incompetence, untrustworthiness, or
6 financial irresponsibility,

7 “(B) the arrangement, or the sponsor
8 thereof, is using such methods or practices in
9 the conduct of its operations, so as to render its
10 further transaction of operations hazardous or
11 injurious to participating employers, or covered
12 individuals,

13 “(C) the arrangement, or the sponsor
14 thereof, has refused to be examined in accord-
15 ance with this part or to produce its accounts,
16 records, and files for examination in accordance
17 with this part, or

18 “(D) any of the officers of the arrange-
19 ment, or the sponsor thereof, has refused to
20 give information with respect to the affairs of
21 the arrangement or the sponsor or to perform
22 any other legal obligation relating to such an
23 examination when required by the Secretary in
24 accordance with this part.

1 Any such suspension or revocation under this subsection
2 shall be effective only upon a final decision of the Sec-
3 retary made after notice and opportunity for a hearing
4 is provided in accordance with section 710.

5 “(c) SUSPENSION OR REVOCATION OF EXEMPTION
6 UNDER COURT PROCEEDINGS.—An exemption granted to
7 a multiple employer welfare arrangement under this part
8 may be suspended or revoked by a court of competent ju-
9 risdiction in an action by the Secretary brought under
10 paragraph (2), (5), or (6) of section 502(a), except that
11 the suspension or revocation under this subsection shall
12 be effective only upon notification of the Secretary of such
13 suspension or revocation.

14 “(d) NOTIFICATION OF PARTICIPATING EMPLOY-
15 ERS.—All participating employers in a multiple employer
16 welfare arrangement shall be notified of the expiration,
17 suspension, or revocation of an exemption granted to such
18 arrangement under this part, by such persons and in such
19 form and manner as shall be prescribed in regulations of
20 the Secretary, not later than 20 days after such expiration
21 or after receipt of notice of a final decision requiring such
22 suspension or revocation.

23 “(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS,
24 AND REVOCATIONS.—The Secretary shall publish all expi-

1 rations of, and all final decisions to suspend or revoke,
2 exemptions granted under this part.

3 **“SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.**

4 “(a) IN GENERAL.—Any decision by the Secretary
5 which involves the denial of an application by a multiple
6 employer welfare arrangement for an exemption under this
7 part or the suspension or revocation of such an exemption
8 shall contain a statement of the specific reason or reasons
9 supporting the Secretary’s action, including reference to
10 the specific terms of the exemption and the statutory pro-
11 vision or provisions relevant to the determination.

12 “(b) DENIALS OF APPLICATIONS.—In the case of the
13 denial of an application for an exemption under this part,
14 the Secretary shall send a copy of the decision to the appli-
15 cant by certified or registered mail at the address specified
16 in the records of the Secretary. Such decision shall con-
17 stitute the final decision of the Secretary unless the ar-
18 rangement, or any party that would be prejudiced by the
19 decision, files a written appeal of the denial within 30 days
20 after the mailing of such decision. The Secretary may af-
21 firm, modify, or reverse the initial decision. The decision
22 on appeal shall become final upon the mailing of a copy
23 by certified or registered mail to the arrangement or party
24 that filed the appeal.

1 “(c) SUSPENSIONS OR REVOCATIONS OF EXEMP-
2 TION.—In the case of the suspension or revocation of an
3 exemption granted under this part, the Secretary shall
4 send a copy of the decision to the arrangement by certified
5 or registered mail at its address, as specified in the
6 records of the Secretary. Upon the request of the arrange-
7 ment, or any party that would be prejudiced by the sus-
8 pension or revocation, filed within 15 days of the mailing
9 of the Secretary’s decision, the Secretary shall schedule
10 a hearing on such decision by written notice, sent by cer-
11 tified or registered mail to the arrangement or party
12 requesting such hearing. Such notice shall set forth—

13 “(1) a specific date and time for the hearing,
14 which shall be within the 10-day period commencing
15 20 days after the date of the mailing of the notice,
16 and

17 “(2) a specific place for the hearing, which shall
18 be in the District of Columbia or in the State and
19 county thereof (or parish or other similar political
20 subdivision thereof) in which is located the arrange-
21 ment’s principal place of business.

22 The decision as affirmed or modified in such hearing shall
23 constitute the final decision of the Secretary, unless such
24 decision is reversed in such hearing.”.

1 (b) CONFORMING AMENDMENT TO DEFINITION OF
 2 PLAN SPONSOR.—Section 3(16)(B) of such Act (29
 3 U.S.C. 1002(16)(B)) is amended by adding at the end the
 4 following new sentence: “Such term also includes the spon-
 5 sor (as defined in section 701(5)) of a multiple employer
 6 welfare arrangement which is or has been an exempted
 7 multiple employer health plan (as defined in section
 8 701(10)).”.

9 (c) ALTERNATIVE MEANS OF DISTRIBUTION OF
 10 SUMMARY PLAN DESCRIPTIONS.—Section 110 of such
 11 Act (29 U.S.C. 1030) is amended by adding at the end
 12 the following new subsection:

13 “(c) The Secretary shall prescribe, as an alternative
 14 method for distributing summary plan descriptions in
 15 order to meet the requirements of section 104(b)(1) in the
 16 case of multiple employer welfare arrangements providing
 17 benefits consisting of medical care described in section
 18 607(1), a means of distribution of such descriptions by
 19 participating employers.”.

20 (d) CLERICAL AMENDMENT.—The table of contents
 21 in section 1 of the Employee Retirement Income Security
 22 Act of 1974 is amended by inserting after the item relat-
 23 ing to section 608 the following new items:

“PART 7—MULTIPLE EMPLOYER HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Exempted multiple employer health plans relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.

“Sec. 703. Exemption procedure.

“Sec. 704. Eligibility requirements.

“Sec. 705. Additional requirements applicable to exempted multiple employer health plans.

“Sec. 706. Disclosure to participating employers by arrangements providing medical care.

“Sec. 707. Maintenance of reserves.

“Sec. 708. Corrective actions.

“Sec. 709. Expiration, suspension, or revocation of exemption.

“Sec. 710. Review of actions of the secretary.”

1 SEC. 1212. CLARIFICATION OF SCOPE OF PREEMPTION

2 RULES.

3 (a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the
 4 Employee Retirement Income Security Act of 1974 (29
 5 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting “, but
 6 only, in the case of an arrangement which provides medi-
 7 cal care described in section 607(1) and with respect to
 8 which an exemption under part 7 is not in effect,” before
 9 “to the extent not inconsistent with the preceding sections
 10 of this title”.

11 (b) CROSS-REFERENCE.—Section 514(b)(6) of such
 12 Act (29 U.S.C. 1144(b)(6)) is amended by adding at the
 13 end the following new subparagraph:

14 “(E) For additional rules relating to exemption from
 15 subparagraph (A)(ii) of multiple employer welfare ar-
 16 rangements providing medical care, see part 7.”.

1 **SEC. 1213. CLARIFICATION OF TREATMENT OF SINGLE EM-**
2 **PLOYER ARRANGEMENTS.**

3 Section 3(40)(B) of the Employee Retirement Income
4 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-
5 ed—

6 (1) in clause (i), by inserting “for any plan year
7 of any such plan, or any fiscal year of any such
8 other arrangement,” after “single employer”, and by
9 inserting “during such year or at any time during
10 the preceding 1-year period” after “common con-
11 trol”;

12 (2) in clause (iii), by striking “common control
13 shall not be based on an interest of less than 25 per-
14 cent” and inserting “an interest of greater than 25
15 percent may not be required as the minimum inter-
16 est necessary for common control”, and by striking
17 “and” at the end,

18 (3) by redesignating clause (iv) as clause (v),
19 and

20 (4) by inserting after clause (iii) the following
21 new clause:

22 “(iv) in determining, after the application of
23 clause (i), whether benefits are provided to employ-
24 ees of two or more employers, the arrangement shall
25 be treated as having only 1 participating employer
26 if, at the time the determination under clause (i) is

1 made, the number of individuals who are employees
 2 and former employees of any one participating em-
 3 ployer and who are covered under the arrangement
 4 is greater than 95 percent of the aggregate number
 5 of all individuals who are employees or former em-
 6 ployees of participating employers and who are
 7 covered under the arrangement.”.

8 **SEC. 1214. CLARIFICATION OF TREATMENT OF CERTAIN**
 9 **COLLECTIVELY BARGAINED ARRANGE-**
 10 **MENTS.**

11 (a) **IN GENERAL.**—Section 3(40)(A)(i) of the Em-
 12 ployee Retirement Income Security Act of 1974 (29
 13 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

14 “(i) under or pursuant to one or more collective
 15 bargaining agreements,”.

16 (b) **LIMITATIONS.**—Section 3(40) of such Act (29
 17 U.S.C. 1002(40)) is amended by adding at the end the
 18 following new subparagraphs:

19 “(C) Clause (i) of subparagraph (A) shall
 20 apply only if—

21 “(i) the plan or other arrangement,
 22 and the employee organization or any other
 23 entity sponsoring the plan or other ar-
 24 rangement, do not—

1 “(I) utilize the services of any li-
2 censed insurance agent or broker for
3 soliciting or enrolling employers or in-
4 dividuals as participating employers or
5 covered individuals under the plan or
6 other arrangement, or

7 “(II) pay a commission or any
8 other type of compensation to a per-
9 son that is related either to the vol-
10 ume or number of employers or indi-
11 viduals solicited or enrolled as partici-
12 pating employers or covered individ-
13 uals under the plan or other arrange-
14 ment, or to the dollar amount or size
15 of the contributions made by partici-
16 pating employers or covered individ-
17 uals to the plan or other arrangement,
18 “(ii) not less than 85 percent of the
19 covered individuals under the plan or other
20 arrangement are individuals who—

21 “(I) are employed within a bar-
22 gaining unit covered by at least one of
23 the collective bargaining agreements
24 with a participating employer (or are
25 covered on the basis of an individual’s

1 employment in such a bargaining
2 unit), or

3 “(II) are present or former em-
4 ployees of the sponsoring employee or-
5 ganization, of an employer who is or
6 was a party to at least one of the col-
7 lective bargaining agreements, or of
8 the plan or other arrangement or a
9 related plan or arrangement (or are
10 covered on the basis of such present
11 or former employment),

12 “(iii) the plan or other arrangement
13 does not provide benefits to individuals
14 (other than individuals described in clause
15 (ii)(II)) who work outside the standard
16 metropolitan statistical area in which the
17 sponsoring employee organization rep-
18 resents employees (or to individuals (other
19 than individuals described in clause
20 (ii)(II)) on the basis of such work by oth-
21 ers), except that in the case of a sponsor-
22 ing employee organization that represents
23 employees who work outside of any stand-
24 ard metropolitan statistical area, this
25 clause shall be applied by reference to the

1 State in which the sponsoring organization
2 represents employees,

3 “(iv) the employee organization or
4 other entity sponsoring the plan or other
5 arrangement certifies to the Secretary each
6 year, in a form and manner which shall be
7 prescribed in regulations of the Sec-
8 retary—

9 “(I) that the plan or other ar-
10 rangement meets the requirements of
11 clauses (i), (ii), and (iii), and

12 “(II) if, for any year, 10 percent
13 or more of the covered individuals
14 under the plan are individuals not de-
15 scribed in subclause (I) or (II) of
16 clause (ii), the total number of cov-
17 ered individuals and the total number
18 of covered individuals not so de-
19 scribed.

20 “(D)(i) Clause (i) of subparagraph (A)
21 shall not apply to a plan or other arrangement
22 that is established or maintained pursuant to
23 one or more collective bargaining agreements
24 which the National Labor Relations Boards de-
25 termines to have been negotiated or otherwise

1 agreed to in a manner or through conduct
2 which violates section 8(a)(2) of the National
3 Labor Relations Act (29 U.S.C. 158(a)(2)).

4 “(ii)(I) Whenever a State insurance com-
5 missioner has reason to believe that this sub-
6 paragraph is applicable to part or all of a plan
7 or other arrangement, the State insurance com-
8 missioner may file a petition with the National
9 Labor Relations Board for a determination
10 under clause (i), along with sworn written testi-
11 mony supporting the petition.

12 “(II) The Board shall give any such peti-
13 tion priority over all other petitions and cases,
14 other than other petitions under subclause (I)
15 or cases given priority under section 10 of the
16 National Labor Relations Act (29 U.S.C. 160).

17 “(III) The Board shall determine, upon
18 the petition and any response, whether, on the
19 facts before it, the plan or other arrangement
20 was negotiated, created, or otherwise agreed to
21 in a manner or through conduct which violates
22 section 8(a)(2) of the National Labor Relations
23 Act (29 U.S.C. 158(a)(2)). Such determination
24 shall constitute a final determination for pur-
25 poses of this subparagraph and shall be binding

1 in all Federal or State actions with respect to
2 the status of the plan or other arrangement
3 under this subparagraph.

4 “(IV) A person aggrieved by the deter-
5 mination of the Board under subclause (III)
6 may obtain review of the determination in any
7 United States court of appeals in the circuit in
8 which the collective bargaining at issue oc-
9 curred. Commencement of proceedings under
10 this subclause shall not, unless specifically or-
11 dered by the court, operate as a stay of any
12 State administrative or judicial action or pro-
13 ceeding related to the status of the plan or
14 other arrangement, except that in no case may
15 the court stay, before the completion of the re-
16 view, an order which prohibits the enrollment of
17 new individuals into coverage under a plan or
18 arrangement.”.

19 **SEC. 1215. EMPLOYEE LEASING HEALTHCARE ARRANGE-**
20 **MENTS.**

21 (a) **EMPLOYEE LEASING HEALTHCARE ARRANGE-**
22 **MENT DEFINED.**—Section 3 of the Employee Retirement
23 Income Security Act of 1974 (29 U.S.C. 1002) is amended
24 by adding at the end the following new paragraph:

1 “(43) EMPLOYEE LEASING HEALTHCARE ARRANGE-
2 MENT.—

3 “(A) IN GENERAL.—Subject to subparagraph
4 (B), the term ‘employee leasing healthcare arrange-
5 ment’ means any labor leasing arrangement, staff
6 leasing arrangement, extended employee staffing or
7 supply arrangement, or other arrangement under
8 which—

9 “(i) one business or other entity (herein-
10 after in this paragraph referred to as the ‘les-
11 see’), under a lease or other arrangement en-
12 tered into with any other business or other en-
13 tity (hereinafter in this paragraph referred to
14 as the ‘lessor’), receives from the lessor the
15 services of individuals to be performed under
16 such lease or other arrangement, and

17 “(ii) benefits consisting of medical care de-
18 scribed in section 607(1) are provided to such
19 individuals or such individuals and their de-
20 pendents as participants and beneficiaries.

21 “(B) EXCEPTION.—Such term does not include
22 an arrangement described in subparagraph (A) if,
23 under such arrangement, the lessor retains, both le-
24 gally and in fact, a complete right of direction and
25 control within the scope of employment over the in-

1 dividuals whose services are supplied under such
 2 lease or other arrangement, and such individuals
 3 perform a specified function for the lessee which is
 4 separate and divisible from the primary business or
 5 operations of the lessee.”.

6 (b) TREATMENT OF EMPLOYEE LEASING
 7 HEALTHCARE ARRANGEMENTS AS MULTIPLE EMPLOYER
 8 WELFARE ARRANGEMENTS.—Section 3(40) of such Act
 9 (29 U.S.C. 1002(40)) (as amended by the preceding provi-
 10 sions of this title) is further amended by adding at the
 11 end the following new subparagraph:

12 “(E) The term ‘multiple employer welfare arrange-
 13 ment’ includes any employee leasing healthcare arrange-
 14 ment.”.

15 (c) SPECIAL RULES FOR EMPLOYEE LEASING
 16 HEALTHCARE ARRANGEMENTS.—

17 (1) IN GENERAL.—Part 7 of subtitle B of title
 18 I of such Act (as added by the preceding provisions
 19 of this Act) is amended by adding at the end the fol-
 20 lowing new section:

21 **“SEC. 711. SPECIAL RULES FOR EMPLOYEE LEASING**
 22 **HEALTHCARE ARRANGEMENTS.**

23 “(a) IN GENERAL.—The requirements of paragraphs
 24 (1), (2), and (3) of section 704(b) shall be treated as satis-
 25 fied in the case of a multiple employer welfare arrange-

1 ment that is an employee leasing healthcare arrangement
2 if the application for exemption includes information
3 which the Secretary determines to be complete and accu-
4 rate and sufficient to demonstrate that the following
5 requirements are met with respect to the arrangement:

6 “(1) 3-YEAR TENURE.—The lessor has been in
7 operation for not less than 3 years.

8 “(2) SOLICITATION RESTRICTIONS.—Employee
9 leasing services provided under the arrangement are
10 not solicited, advertised, or marketed through li-
11 censed insurance agents or brokers acting in such
12 capacity.

13 “(3) CREATION OF EMPLOYMENT RELATION-
14 SHIP.—

15 “(A) DISCLOSURE STATEMENT.—Written
16 notice is provided to each applicant for employ-
17 ment subject to coverage under the arrange-
18 ment, at the time of application for employment
19 and before commencing coverage under the ar-
20 rangement, stating that the employer is the les-
21 sor under the arrangement.

22 “(B) INFORMED CONSENT.—Each such
23 applicant signs a written statement consenting
24 to the employment relationship with the lessor.

1 “(C) INFORMED RECRUITMENT OF LES-
2 SEE’S EMPLOYEES.—In any case in which the
3 lessor offers employment to an employee of a
4 lessee under the arrangement, the lessor in-
5 forms each employee in writing that his or her
6 acceptance of employment with the lessor is vol-
7 untary and that refusal of such offer will not be
8 deemed to be resignation from or abandonment
9 of current employment.

10 “(4) REQUISITE EMPLOYER-EMPLOYEE RELA-
11 TIONSHIP UNDER ARRANGEMENT.—Under the em-
12 ployer-employee relationship with the employees of
13 the lessor—

14 “(A) the lessor retains the ultimate author-
15 ity to hire, terminate, and reassign such em-
16 ployees,

17 “(B) the lessor is responsible for the pay-
18 ment of wages, payroll-related taxes, and em-
19 ployee benefits, without regard to payment by
20 the lessee to the lessor for its services,

21 “(C) the lessor maintains the right of di-
22 rection and control over its employees, except to
23 the extent that the lessee is responsible for su-
24 pervision of the work performed consistent with

1 the lessee's responsibility for its product or
2 service, and

3 “(D) in accordance with section 301(a) of
4 the Labor Management Relations Act, 1947 (29
5 U.S.C. 185(a)), the lessor retains in the ab-
6 sence of an applicable collective bargaining
7 agreement, the right to enter into arbitration
8 and to decide employee grievances, and

9 “(E) no owner, officer, or director of, or
10 partner in, a lessee is an employee of the lessor,
11 and not more than 10 percent of the individuals
12 covered under the arrangement consist of own-
13 ers, officers, or directors of, or partners in,
14 such a lessee (or any combination thereof).

15 “(b) DEFINITIONS.—For purposes of this section—

16 “(1) LESSOR.—The term ‘lessor’ means the
17 business or other entity from which services of indi-
18 viduals are obtained under an employee leasing
19 healthcare arrangement.

20 “(2) LESSEE.—The term ‘lessee’ means a busi-
21 ness or other entity which receives the services of in-
22 dividuals provided under an employee leasing
23 healthcare arrangement.”.

24 (2) CLERICAL AMENDMENT.—The table of con-
25 tents in section 1 of such Act (as amended by the

1 preceding provisions of this title) is further amended
 2 by inserting after the item relating to section 710
 3 the following new item:

“Sec. 711. Employee leasing healthcare arrangements.”.

4 **SEC. 1216. ENFORCEMENT PROVISIONS RELATING TO MUL-**
 5 **TIPLE EMPLOYER WELFARE ARRANGEMENTS**
 6 **AND EMPLOYEE LEASING HEALTHCARE AR-**
 7 **RANGEMENTS.**

8 (a) ENFORCEMENT OF FILING REQUIREMENTS.—

9 Section 502 of the Employee Retirement Income Security
 10 Act of 1974 (29 U.S.C. 1132) is amended—

11 (1) in subsection (a)(6), by striking “subsection
 12 (c)(2) or (i) or (l)” and inserting “paragraph (2) or
 13 (4) of subsection (c) or subsection (i) or (l)”; and

14 (2) by adding at the end of subsection (c) the
 15 following new paragraph:

16 “(4) The Secretary may assess a civil penalty against
 17 any person of up to \$1,000 a day from the date of such
 18 person’s failure or refusal to file the information required
 19 to be filed with the Secretary under section 101(e).”.

20 (b) ACTIONS BY STATES IN FEDERAL COURT.—Sec-
 21 tion 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

22 (1) in paragraph (5), by striking “or” at the
 23 end;

24 (2) in paragraph (6), by striking the period and
 25 inserting “, or”; and

(3) by adding at the end the following:

“(7) by a State official having authority under the law of such State to enforce the laws of such State regulating insurance, to enjoin any act or practice which violates any provision of part 7 which such State has the power to enforce under part 7.”.

(c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of such Act (29 U.S.C. 1131) is amended—

(1) by inserting “(a)” after “SEC. 501.”; and

(2) by adding at the end the following new subsection:

“(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee’s beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

“(1) being an exempted multiple employer welfare arrangement (as defined in section 701(10)),

“(2) being an employee leasing healthcare arrangement under an exemption granted under part 7, or

1 “(3) having been established or maintained
2 under or pursuant to a collective bargaining agree-
3 ment,
4 shall, upon conviction, be imprisoned not more than five
5 years, be fined under title 18, United States Code, or
6 both.”.

7 (d) CEASE ACTIVITIES ORDERS.—Section 502 of
8 such Act (29 U.S.C. 1132) is amended by adding at the
9 end the following new subsection:

10 “(m)(1) Subject to paragraph (2), upon application
11 by the Secretary showing the operation, promotion, or
12 marketing of a multiple employer welfare arrangement
13 providing benefits consisting of medical care described in
14 section 607(1) that—

15 “(A) is not licensed, registered, or otherwise ap-
16 proved under the insurance laws of the States in
17 which the arrangement offers or provides benefits, or

18 “(B) is not operating in accordance with the
19 terms of an exemption granted by the Secretary
20 under part 7,

21 a district court of the United States shall enter an order
22 requiring that the arrangement cease activities.

23 “(2) Paragraph (1) shall not apply in the case of a
24 multiple employer welfare arrangement if the arrangement
25 shows that—

1 “(A) coverage under it is fully insured, within
2 the meaning of section 701(9),

3 “(B) it is licensed, registered, or otherwise ap-
4 proved in each State in which it offers or provides
5 benefits, except to the extent that such State does
6 not require licensing, registration, or approval of
7 multiple employer welfare arrangements under which
8 all coverage is fully insured, and

9 “(C) with respect to each such State, it is oper-
10 ating in accordance with applicable State insurance
11 laws that are not superseded under section 514.

12 “(3) The court may grant such additional equitable
13 or remedial relief, including any relief available under this
14 title, as it deems necessary to protect the interests of the
15 public and of persons having claims for benefits against
16 the arrangement.”.

17 (e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—

18 Section 503 of such Act (29 U.S.C. 1133) is amended by
19 adding at the end (after and below paragraph (2)) the fol-
20 lowing new sentence: “The terms of each multiple em-
21 ployer welfare arrangement to which this section applies
22 and which provides benefits consisting of medical care de-
23 scribed in section 607(1) shall require the operating com-
24 mittee or the named fiduciary (as applicable) to ensure

1 that the requirements of this section are met in connection
2 with claims filed under the arrangement.”.

3 **SEC. 1217. SOLVENCY REQUIREMENTS FOR CERTAIN SELF-**
4 **INSURED GROUP HEALTH PLANS.**

5 (a) IN GENERAL.—The Secretary of Labor shall pre-
6 scribe by regulation provisions described in subsection (b)
7 applicable to group health plans which are not multiple
8 employer health plans, which offer coverage with respect
9 to employees of small employers (as defined in section
10 1131), and under which some or all coverage is not fully
11 insured (within the meaning of section 701(9) of the Em-
12 ployee Retirement Income Security Act of 1974)), for the
13 purpose of promoting adequate funding of such plans.

14 (b) REQUIREMENTS.—

15 (1) GENERAL RULE.—Except as provided in
16 paragraph (2), the provisions described in subsection
17 (a) shall require the group health plan to establish
18 and maintain reserves, consisting of—

19 (A) a reserve for unearned contributions,
20 and

21 (B) a reserve for payment of claims re-
22 ported and not yet paid and claims incurred but
23 not yet reported, and for expected administra-
24 tive costs with respect to such claims.

(2) EXCEPTION.—The Secretary may in such regulations permit a group health plan to substitute, for all or part of the reserves required under paragraph (1), such security, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis.

(c) CRITERIA FOR COMPLIANCE.—The criteria that the Secretary shall take into account in determining compliance with the requirements described in subsection (b) shall include:

(1) the size of the employer involved;

(2) the benefit package provided under the plan;

(3) whether the coverage provided under the plan is in the form of a fee-for-service arrangement, a health maintenance organization, or any other type of coverage;

(4) the extent to which excess/stop loss coverage is maintained for the plan; and

(5) the nature of any security, guarantee, or other financial arrangement described in subsection (b)(2) obtained for the plan.

1 **SEC. 1218. FILING REQUIREMENTS FOR MULTIPLE EM-**
2 **PLOYER WELFARE ARRANGEMENTS PROVID-**
3 **ING HEALTH BENEFITS.**

4 Section 101 of the Employee Retirement Income Se-
5 curity Act of 1974 (29 U.S.C. 1021) is amended—

6 (1) by redesignating subsection (e) as sub-
7 section (f); and

8 (2) by inserting after subsection (d) the follow-
9 ing new subsection:

10 “(e)(1) Each multiple employer welfare arrangement
11 shall file with the Secretary a registration statement de-
12 scribed in paragraph (2) within 60 days before commenc-
13 ing operations (in the case of an arrangement commencing
14 operations on or after January 1, 1995) and no later than
15 February 15 of each year (in the case of an arrangement
16 in operation since the beginning of such year), unless, as
17 of the date by which such filing otherwise must be made,
18 such arrangement provides no benefits consisting of medi-
19 cal care described in section 607(1).

20 “(2) Each registration statement—

21 “(A) shall be filed in such form, and contain
22 such information concerning the multiple employer
23 welfare arrangement and any persons involved in its
24 operation (including whether coverage under the ar-
25 rangement is fully insured), as shall be provided in

1 regulations which shall be prescribed by the Sec-
2 retary, and

3 “(B) if coverage under the arrangement is not
4 fully insured, shall contain a certification that copies
5 of such registration statement have been transmitted
6 by certified mail to—

7 “(i) in the case of an arrangement which
8 is an exempted multiple employer health plan
9 (as defined in section 701(10)), the State insur-
10 ance commissioner of the domicile State of such
11 arrangement, or

12 “(ii) in the case of an arrangement which
13 is not an exempted multiple employer health
14 plan, the State insurance commissioner of each
15 State in which the arrangement is located.

16 “(3) The person or persons responsible for filing the
17 annual registration statement are—

18 “(A) the trustee or trustees so designated by
19 the terms of the instrument under which the mul-
20 tiple employer welfare arrangement is established or
21 maintained, or

22 “(B) in the case of a multiple employer welfare
23 arrangement for which the trustee or trustees can-
24 not be identified, or upon the failure of the trustee
25 or trustees of an arrangement to file, the person or

1 persons actually responsible for the acquisition, dis-
 2 position, control, or management of the cash or
 3 property of the arrangement, irrespective of whether
 4 such acquisition, disposition, control, or management
 5 is exercised directly by such person or persons or
 6 through an agent designated by such person or
 7 persons.

8 “(4) Any agreement entered into under section
 9 506(c) with a State as the primary domicile State with
 10 respect to any multiple employer welfare arrangement
 11 shall provide for simultaneous filings of reports required
 12 under this subsection with the Secretary and with the
 13 State insurance commissioner of such State.”.

14 **SEC. 1219. COOPERATION BETWEEN FEDERAL AND STATE**
 15 **AUTHORITIES.**

16 Section 506 of the Employee Retirement Income Se-
 17 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
 18 at the end the following new subsection:

19 “(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE
 20 EMPLOYER WELFARE ARRANGEMENTS.—

21 “(1) STATE ENFORCEMENT.—

22 “(A) AGREEMENTS WITH STATES.—A
 23 State may enter into an agreement with the
 24 Secretary for delegation to the State of some or
 25 all of the Secretary’s authority under sections

1 502 and 504 to enforce the provisions of this
2 title applicable to multiple employer welfare ar-
3 rangements which are or have been exempted
4 multiple employer health plans (as defined in
5 section 701(10)). The Secretary shall enter into
6 the agreement if the Secretary determines that
7 the delegation provided for therein would not
8 result in a lower level or quality of enforcement
9 of the provisions of this title.

10 “(B) DELEGATIONS.—Any department,
11 agency, or instrumentality of a State to which
12 authority is delegated pursuant to an agree-
13 ment entered into under this paragraph may, if
14 authorized under State law and to the extent
15 consistent with such agreement, exercise the
16 powers of the Secretary under this title which
17 relate to such authority.

18 “(C) CONCURRENT AUTHORITY OF THE
19 SECRETARY.—If the Secretary delegates author-
20 ity to a State in an agreement entered into
21 under subparagraph (A), the Secretary may
22 continue to exercise such authority concurrently
23 with the State.

24 “(D) RECOGNITION OF PRIMARY DOMICILE
25 STATE.—In entering into any agreement with a

1 State under subparagraph (A), the Secretary
2 shall ensure that, as a result of such agreement
3 and all other agreements entered into under
4 subparagraph (A), only one State will be recog-
5 nized, with respect to any particular multiple
6 employer welfare arrangement, as the primary
7 domicile State to which authority has been dele-
8 gated pursuant to such agreements.

9 “(2) ASSISTANCE TO STATES.—The Secretary
10 shall—

11 “(A) provide enforcement assistance to the
12 States with respect to multiple employer welfare
13 arrangements, including, but not limited to, co-
14 ordinating Federal and State efforts through
15 the establishment of cooperative agreements
16 with appropriate State agencies under which
17 the Pension and Welfare Benefits Administra-
18 tion keeps the States informed of the status of
19 its cases and makes available to the States in-
20 formation obtained by it,

21 “(B) provide continuing technical assist-
22 ance to the States with respect to issues involv-
23 ing multiple employer welfare arrangements
24 and this Act,

“(C) assist the States in obtaining from the Office of Regulations and Interpretations timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

“(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.”.

SEC. 1220. EFFECTIVE DATE; TRANSITIONAL RULES.

(a) **EFFECTIVE DATE.**—The amendments made by this part shall take effect January 1, 1995, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) **TRANSITIONAL RULES.**—If the sponsor of a multiple employer welfare arrangement which, as of January 1, 1995, provides benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)) files with the Secretary of Labor an application for an exemption under part 7 of subtitle B of title I of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A)

1 of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply
2 with respect to such arrangement during the 18-month pe-
3 riod following such date. If the Secretary determines, at
4 any time after the date of enactment of this Act, that any
5 such exclusion from coverage under the provisions of such
6 section 514(b)(6)(A) of such Act of a multiple employer
7 welfare arrangement would be detrimental to the interests
8 of individuals covered under such arrangement, such ex-
9 clusion shall cease as of the date of the determination.
10 Any determination made by the Secretary under this sub-
11 section shall be in the Secretary's sole discretion.

12 **PART 3—ENCOURAGEMENT OF MULTIPLE EM-**
13 **PLOYER ARRANGEMENTS PROVIDING BASIC**
14 **HEALTH BENEFITS**

15 **SEC. 1221. ELIMINATING COMMONALITY OF INTEREST OR**
16 **GEOGRAPHIC LOCATION REQUIREMENT FOR**
17 **TAX EXEMPT TRUST STATUS.**

18 (a) IN GENERAL.—Paragraph (9) of section 501(c)
19 of the Internal Revenue Code of 1986 (relating to exempt
20 organizations) is amended—

21 (1) by inserting “(A)” after “(9)”; and

22 (2) by adding at the end the following:

23 “(B) Any determination of whether a multiple
24 employer health plan (as defined in section 701(10)
25 of the Employee Retirement Income Security Act of

1974) or an insured multiple employer health plan (as defined in section 701(11) of such Act) is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location if—

“(i) such plan provides at least standard coverage (consistent with section 102(c) of the Affordable Health Care Now Act of 1994), and

“(ii) in the case of an insured multiple employer health plan, it meets the requirements enforceable under section 514(b)(6)(B)(i) of the Employee Retirement Income Security Act of 1974 to the extent not preempted by section 1202 of the Affordable Health Care Now Act of 1994.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to determinations made on or after January 1, 1995.

SEC. 1222. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS.

(a) **IN GENERAL.**—Section 110 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1030), as amended by section 1211(c) of this subtitle, is amended by adding at the end the following new subsection:

1 “(d) The Secretary shall prescribe by regulation or
 2 otherwise an alternative method providing for the filing
 3 of a single annual report (as referred to in section
 4 104(a)(1)(A)) with respect to all employers who are par-
 5 ticipating employers under a multiple employer welfare ar-
 6 rangement under which all coverage consists of medical
 7 care (described in section 607(1)) and is fully insured (as
 8 defined in section 701(9)).”.

9 (b) **EFFECTIVE DATE.**—The amendment made by
 10 subsection (a) shall take effect on the date of the enact-
 11 ment of this Act. The Secretary of Labor shall prescribe
 12 the alternative method referred to in section 110(d) of the
 13 Employee Retirement Income Security Act of 1974, as
 14 added by such amendment, within 90 days after the date
 15 of the enactment of this Act.

16 **SEC. 1223. COMPLIANCE WITH COVERAGE REQUIREMENTS**
 17 **THROUGH MULTIPLE EMPLOYER HEALTH AR-**
 18 **RANGEMENTS.**

19 (a) **COMPLIANCE WITH APPLICABLE REQUIREMENTS**
 20 **THROUGH MULTIEMPLOYER PLANS.**—In any case in
 21 which an eligible employee is, for any plan year, a partici-
 22 pant in a group health plan which is a multiemployer plan,
 23 the requirements of section 1001(a) shall be deemed to
 24 be met with respect to such employee for such plan year
 25 if the employer requirements of subsection (c) are met

1 with respect to the eligible employee, irrespective of wheth-
2 er, or to what extent, the employer makes employer con-
3 tributions on behalf of the eligible employee.

4 (b) COMPLIANCE WITH APPLICABLE REQUIREMENTS
5 THROUGH OTHER MULTIPLE EMPLOYER HEALTH AR-
6 RANGEMENTS.—

7 (1) IN GENERAL.—In any case in which an em-
8 ployer is, for any plan year, a participating employer
9 (as defined in paragraph (3)) in an exempted mul-
10 tiple employer health plan or in a multiple employer
11 welfare arrangement under which all coverage con-
12 sists of medical care (described in section 607(1) of
13 the Employee Retirement Income Security Act of
14 1974) and is fully insured (as defined in section
15 701(9) of such Act), the requirements of section
16 1001(a) shall be deemed to be met (and the ERISA
17 requirements of paragraph (2) shall be deemed to be
18 met by the employer) with respect to an eligible em-
19 ployee of the employer if—

20 (A) the employer requirements of sub-
21 section (c) are met with respect to the eligible
22 employee, and

23 (B) the applicable ERISA requirements of
24 paragraph (2) are met by the plan or arrange-
25 ment with respect to the plan or arrangement,

1 irrespective of whether, or to what extent, the em-
2 ployer makes employer contributions on behalf of the
3 eligible employee.

4 (2) APPLICABLE ERISA REQUIREMENTS.—The
5 applicable ERISA requirements of this paragraph
6 are the requirements of—

7 (A) part 1 of subtitle B of title I of the
8 Employee Retirement Income Security Act of
9 1974 (relating to reporting and disclosure),

10 (B) section 503 of such Act (relating to
11 claims procedure), and

12 (C) part 6 of subtitle B of such title I (re-
13 lating to group health plans),

14 to the extent that such requirements relate to em-
15 ployers as plan sponsors or plan administrators.

16 (3) PARTICIPATING EMPLOYER.—In this sub-
17 section, the term “participating employer” means, in
18 connection with an exempted multiple employer
19 health plan or a multiple employer welfare arrange-
20 ment under which all coverage consists of medical
21 care (described in section 607(1) of the Employee
22 Retirement Income Security Act of 1974) and is
23 fully insured (as defined in section 701(9) of such
24 Act), any employer if any of its employees, or any
25 of the dependents of its employees, are or were cov-

1 ered under such plan or arrangement in connection
2 with the employment of the employees.

3 (c) EMPLOYER REQUIREMENTS.—The employer re-
4 quirements of this subsection are met under a plan or ar-
5 rangement with respect to an eligible employee if—

6 (1) the employee is eligible under the plan or
7 arrangement to elect coverage on an annual basis
8 and is provided a reasonable opportunity to make
9 the election in such form and manner and at such
10 times as are provided by the plan or arrangement,

11 (2) subject to section 1001(c), such coverage in-
12 cludes at least the standard coverage (consistent
13 with section 1102(c)),

14 (3) the employer facilitates collection of any
15 employee contributions under the plan or arrange-
16 ment and permits the employee to elect to have em-
17 ployee contributions under the plan or arrangement
18 collected through payroll deduction, and

19 (4) in the case of a plan or arrangement to
20 which part 1 of subtitle B of title I of the Employee
21 Retirement Income Security Act of 1974 does not
22 otherwise apply, the employer provides to the em-
23 ployee a summary plan description described in sec-
24 tion 102(a)(1) of such Act in the form and manner

and at such times as are required under such part
1 with respect to employee welfare benefit plans.

Subtitle D—Health Deduction Fairness

SEC. 1301. PERMANENT EXTENSION AND INCREASE IN HEALTH INSURANCE TAX DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.

(a) PERMANENT EXTENSION OF DEDUCTION.—

(1) IN GENERAL.—Subsection (l) of section 162
of the Internal Revenue Code of 1986 (relating to
special rules for health insurance costs of self-em-
ployed individuals) is amended by striking paragraph
(6).

(2) EFFECTIVE DATE.—The amendment made
by this subsection shall apply to taxable years begin-
ning after December 31, 1993.

(b) INCREASE IN AMOUNT OF DEDUCTION; INSUR- ANCE PURCHASED MUST MEET CERTAIN STANDARDS.—

(1) INCREASE IN AMOUNT OF DEDUCTION.—
Paragraph (1) of section 162(l) of such Code is
amended by striking “25 percent of” and inserting
“100 percent (25 percent in the case of taxable
years beginning in 1994 or 1995 and 50 percent in
the case of taxable years beginning in 1996 or 1997)
of”.

(2) INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—Paragraph (2) of section 162(l) of such Code is amended by adding at the end thereof the following new subparagraph:

“(C) TREATMENT OF GROUP HEALTH PLANS.—For purposes of this subsection, an amount paid into a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of 1974) shall be deemed to be an amount paid for insurance which constitutes medical care.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1994.

SEC. 1302. DEDUCTION OF HEALTH INSURANCE PREMIUMS FOR CERTAIN PREVIOUSLY UNINSURED INDIVIDUALS.

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

“(f) DEDUCTION FOR CERTAIN HEALTH INSURANCE COSTS DETERMINED WITHOUT REGARD TO ADJUSTED GROSS INCOME THRESHOLD.—

1 “(1) IN GENERAL.—Subsection (a) shall be ap-
 2 plied without regard to the limitation based on ad-
 3 justed gross income in the case of the applicable per-
 4 centage of the amounts paid for insurance referred
 5 to in section 162(l)(2)(C) (and including payments
 6 referred to in section 162(l)(2)(D)).

7 “(2) APPLICABLE PERCENTAGE.—For purposes
 8 of paragraph (1), the term ‘applicable percentage’
 9 means—

10 “(A) 25 percent for taxable years begin-
 11 ning in 1994 or 1995,

12 “(B) 50 percent for taxable years begin-
 13 ning in 1996 or 1997, and

14 “(C) 100 percent for taxable years begin-
 15 ning after 1997.

16 “(3) DEDUCTION NOT ALLOWED TO INDIVID-
 17 UALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COV-
 18 ERAGE.—

19 “(A) IN GENERAL.—Paragraph (1) shall
 20 not apply to any individual—

21 “(i) who is eligible to participate in
 22 any subsidized health plan maintained by
 23 an employer of such individual or the
 24 spouse of such individual, or

1 “(ii) who is (or whose spouse is) a
2 member of a subsidized class of employees
3 of an employer of such individual or
4 spouse.

5 “(B) SUBSIDIZED CLASS.—For purposes of
6 subparagraph (A), an individual is a member of
7 a subsidized class of employees of an employer
8 if, at any time during the 3 calendar years end-
9 ing with or within the taxable year, any mem-
10 ber of such class was eligible to participate in
11 any subsidized health plan maintained by such
12 employer.

13 “(C) SPECIAL RULES.—

14 “(i) CONTROLLED GROUPS.—All per-
15 sons treated as a single employer under
16 subsection (a) or (b) of section 52 or sub-
17 section (m) or (o) of section 414 shall be
18 treated as a single employer for purposes
19 of subparagraph (B).

20 “(ii) CLASSES.—Classes of employees
21 shall be determined under regulations pre-
22 scribed by the Secretary based on such fac-
23 tors as the Secretary determines appro-
24 priate to carry out the purposes of this
25 subsection.

1 “(4) COORDINATION WITH DEDUCTION FOR
2 OTHER AMOUNTS.—Amounts allowable as a deduc-
3 tion under subsection (a) by reason of this sub-
4 section shall not be taken into account in determin-
5 ing the deduction under subsection (a) for other
6 amounts.

7 “(5) SUBSECTION NOT TO APPLY TO INDIVID-
8 UALS ELIGIBLE FOR MEDICARE.—This subsection
9 shall not apply to amount paid for insurance cover-
10 ing an individual who is eligible for benefits under
11 title XVIII of the Social Security Act.”.

12 (b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL
13 ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
14 of section 62 of such Code is amended by inserting after
15 paragraph (15) the following new paragraph:

16 “(16) COSTS OF CERTAIN HEALTH INSURANCE.—The deduction allowed by section 213 to the
17 extent allowable by reason of section 213(f).”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to taxable years beginning after
21 December 31, 1994.

**Subtitle E—Improved Access to
Community Health Services**

**PART 1—INCREASED AUTHORIZATION FOR
COMMUNITY AND MIGRANT HEALTH CENTERS**

**SEC. 1401. GRANT PROGRAM TO PROMOTE PRIMARY
HEALTH CARE SERVICES FOR UNDERSERVED
POPULATIONS.**

(a) AUTHORIZATION.—The Secretary of Health and Human Services shall provide for a program of grants to migrant and community health centers (receiving grants or contracts under section 329, 330, or 340 of the Public Health Service Act) in order to promote the provision of primary health care services for underserved individuals. Such grants may be used—

(1) to promote the provision of off-site services (through means such as mobile medical clinics);

(2) to improve birth outcomes in areas with high infant mortality and morbidity;

(3) to establish primary care clinics in areas identified as in need of such clinics; and

(4) for recruitment and training costs of necessary providers and operating costs for unreimbursed services.

1 (b) CONDITIONS.—(1) Grants under this subsection
2 shall only be made upon application, approved by the Sec-
3 retary.

4 (2) The amount of grants made under this section
5 shall be determined by the Secretary.

6 (c) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated—

8 (1) in fiscal year 1995, \$100,000,000,

9 (2) in fiscal year 1996, \$200,000,000,

10 (3) in fiscal year 1997, \$300,000,000,

11 (4) in fiscal year 1998, \$400,000,000, and

12 (5) in fiscal year 1999, \$500,000,000,

13 to carry out this section. Of the amounts appropriated
14 each fiscal year under this section, at least 10 percent
15 shall be used for grants described in subsection (a)(1) and
16 at least 10 percent shall be used for grants described in
17 subsection (a)(2). The Secretary may use not to exceed
18 50 percent of the amounts appropriated to carry out this
19 section for the purpose of making new grants or contracts
20 under sections 329, 330, and 340 of the Public Health
21 Service Act.

22 (d) STUDY AND REPORT.—The Secretary shall con-
23 duct a study of the impact of the grants made under this
24 section to migrant and community health centers on ac-
25 cess to health care, birth outcomes, and the use of emer-

1 gency room services. Not later than 2 years after the date
 2 of the enactment of this Act, the Secretary shall submit
 3 to Congress a report on such study and on recommenda-
 4 tions for changes in the programs under this section in
 5 order to promote the appropriate use of cost-effective out-
 6 patient services.

7 **PART 2—GRANTS FOR PROJECTS FOR**
 8 **COORDINATING DELIVERY OF SERVICES**

9 **SEC. 1411. PROJECTS FOR COORDINATING DELIVERY OF**
 10 **OUTPATIENT PRIMARY HEALTH SERVICES.**

11 Part D of title III of the Public Health Service Act
 12 (42 U.S.C. 254b et seq.) is amended by adding at the end
 13 the following new subpart:

14 “Subpart VII—Delivery of Services

15 “PROJECTS FOR COORDINATING DELIVERY OF SERVICES

16 “SEC. 340E. (a) AUTHORITY FOR GRANTS.—

17 “(1) IN GENERAL.—The Secretary may make
 18 grants to public and nonprofit private entities to
 19 carry out demonstration projects for the purpose of
 20 increasing access to outpatient primary health serv-
 21 ices in geographic areas described in subsection (b)
 22 through coordinating the delivery of such services
 23 under Federal, State, local, and private programs.

1 “(2) REQUIREMENT REGARDING PLAN.—The
2 Secretary may make a grant under paragraph (1)
3 only if—

4 “(A) the applicant involved has received a
5 grant under subsection (l) and the Secretary
6 has approved the plan developed with such
7 grant; and

8 “(B) the applicant agrees to carry out the
9 project under paragraph (1) in accordance with
10 the plan.

11 “(b) QUALIFIED HEALTH SERVICE AREAS.—

12 “(1) IN GENERAL.—A geographic area de-
13 scribed in this subsection is a geographic area
14 that—

15 “(A) is a rational area for the delivery of
16 health services;

17 “(B) has a population of not more than
18 500,000 individuals; and

19 “(C)(i) has been designated by the Sec-
20 retary as an area with a shortage of personal
21 health services; or

22 “(ii) has a significant number of individ-
23 uals who have low incomes or who have insuffi-
24 cient insurance regarding health care.

1 “(2) AUTHORITY REGARDING MULTIPLE POLIT-
2 ICAL SUBDIVISIONS.—The Secretary shall make a
3 determination of whether a geographic area is a geo-
4 graphic area described in paragraph (1) without re-
5 gard to whether the area is a political subdivision,
6 without regard to whether the area is located in 2
7 or more political subdivisions or States, and without
8 regard to whether the area encompasses 2 or more
9 political subdivisions.

10 “(c) PREFERENCES IN MAKING GRANTS.—In making
11 grants under subsection (a), the Secretary shall give pref-
12 erence to applicants demonstrating that, with respect to
13 the outpatient primary health services that will be the sub-
14 ject of the project conducted by the applicant under such
15 subsection—

16 “(1)(A) the project will result in the reduction
17 of administrative expenses associated with such serv-
18 ices by increasing the efficiency of the administrative
19 processes of the providers participating in the
20 project, and (B) the resulting savings will be ex-
21 pended for the direct provision of such services for
22 the designated population; or

23 “(2) the services that will be the subject of the
24 project will be provided in facilities that are
25 underutilized.

1 “(d) ACTIVITIES OF PROJECT MUST SERVE DES-
2 IGNATED POPULATION.—The Secretary may make a
3 grant under subsection (a) to an applicant only if the ap-
4 plicant demonstrates that carrying out the project under
5 such subsection will increase access to outpatient primary
6 health services for a significant segment of the designated
7 population.

8 “(e) MATCHING FUNDS.—

9 “(1) IN GENERAL.—With respect to the costs of
10 the project to be carried out under subsection (a) by
11 an applicant, the Secretary may make a grant under
12 such subsection only if the applicant agrees to make
13 available (directly or through donations from public
14 or private entities) non-Federal contributions toward
15 such costs in an amount that is not less than 50
16 percent of such costs.

17 “(2) DETERMINATION OF AMOUNT CONTRIB-
18 UTED.—Non-Federal contributions required in para-
19 graph (1) may be in cash or in kind, fairly evalu-
20 ated, including plant, equipment, or services.
21 Amounts provided by the Federal Government, or
22 services assisted or subsidized to any significant ex-
23 tent by the Federal Government, may not be in-
24 cluded in determining the amount of such non-Fed-
25 eral contributions.

1 “(f) CERTAIN LIMITATIONS REGARDING GRANTS.—

2 “(1) PROVISION OF HEALTH SERVICES; CON-
3 STRUCTION OF FACILITIES.—The Secretary may
4 make a grant under subsection (a) only if the appli-
5 cant involved agrees that the grant will not be ex-
6 pended for the direct provision of any health service
7 or for the construction or renovation of facilities.

8 “(2) DURATION AND AMOUNT OF GRANT.—The
9 period during which payments are made for a
10 project under subsection (a) may not exceed 4 years,
11 and the aggregate amount of such payments for the
12 period may not exceed \$200,000. The provision of
13 such payments shall be subject to annual approval
14 by the Secretary of the payments and subject to the
15 availability of appropriations for the fiscal year in-
16 volved to make the payments.

17 “(3) FINANCIAL CAPACITY FOR CONTINUATION
18 OF PROJECT AFTER TERMINATION OF GRANT.—The
19 Secretary may make a grant under subsection (a)
20 only if the Secretary determines that there is a rea-
21 sonable basis for believing that, after termination of
22 payments under such subsection pursuant to para-
23 graph (2), the project under such subsection will
24 have the financial capacity to continue operating.

1 “(g) AGREEMENTS AMONG PARTICIPANTS IN
2 PROJECTS.—

3 “(1) REQUIRED PARTICIPANTS.—The Secretary
4 may make a grant under subsection (a) only if the
5 applicant for the grant has, for purposes of carrying
6 out a project under such subsection, entered into
7 agreements with—

8 “(A) the chief public health officers, and
9 the chief health officers for the elementary and
10 secondary schools, of each of the political sub-
11 divisions of the qualified health service area in
12 which the project under such subsection is to be
13 carried out (or, in the case of a political sub-
14 division that does not have such an official,
15 with another appropriate official of such sub-
16 division);

17 “(B) each hospital in the qualified health
18 service area;

19 “(C) representatives of entities in such
20 area that provide outpatient primary health
21 services under Federal, State, local, or private
22 programs;

23 “(D) representatives of businesses in such
24 area, including small businesses; and

1 “(E) representatives of nonprofit private
2 entities in such area.

3 “(2) OPTIONAL PARTICIPANTS.—With respect
4 to compliance with this section, a grantee under sub-
5 section (a) may, for purposes of carrying out a
6 project under such subsection, enter into such agree-
7 ments with public and private entities in the quali-
8 fied health service area involved (in addition to the
9 entities specified in paragraph (1)) as the grantee
10 may elect.

11 “(h) EXPENDITURES OF GRANT.—With respect to a
12 project under subsection (a), the purposes for which a
13 grant under such subsection may be expended include (but
14 are not limited to) expenditures to increase the efficiency
15 of the administrative processes of providers participating
16 in the project, paying the costs of hiring and compensating
17 staff, obtaining computers and other equipment (including
18 vehicles to transport individuals to programs providing
19 outpatient primary health services), and developing and
20 operating provider networks.

21 “(i) MAINTENANCE OF EFFORT.—In the case of serv-
22 ices and populations that are the subject of a project
23 under subsection (a), the Secretary may make such a
24 grant for a fiscal year only if the applicant involved agrees
25 that the applicant, and each entity making an agreement

1 under subsection (g), will maintain expenditures of non-
2 Federal amounts for such services and populations at a
3 level that is not less than the level of such expenditures
4 maintained by the applicant and the entity, respectively,
5 for the fiscal year preceding the first fiscal year for which
6 the applicant receives such a grant.

7 “(j) REPORTS TO SECRETARY.—The Secretary may
8 make a grant under subsection (a) only if the applicant
9 involved agrees to submit to the Secretary such reports
10 on the project carried out under such subsection as the
11 Secretary may require.

12 “(k) EVALUATIONS AND DISSEMINATION OF INFOR-
13 MATION.—The Secretary shall provide for evaluations of
14 projects carried out under subsection (a), and for the col-
15 lection and dissemination of information developed as a
16 result of such projects and as a result of similar projects.

17 “(l) PLANNING GRANTS.—

18 “(1) IN GENERAL.—The Secretary may make
19 grants to public and nonprofit private entities for
20 the purpose of developing plans to carry out projects
21 under subsection (a). Such a grant may be made
22 only if the applicant involved submits to the Sec-
23 retary information—

1 “(A) providing a detailed statement of the
2 proposal of the applicant for carrying out the
3 project;

4 “(B) identifying the geographic area in
5 which the project is to be carried out; and

6 “(C) demonstrating that the area is a
7 qualified health service area and that the pro-
8 posal otherwise is in accordance with the re-
9 quirements established in this section for the
10 receipt of a grant under subsection (a).

11 “(2) DURATION AND AMOUNT OF GRANT.—The
12 period during which payments are made under para-
13 graph (1) for the development of a plan under such
14 paragraph may not exceed 1 year, and the amount
15 of such payments may not exceed \$100,000.

16 “(m) APPLICATION FOR GRANT.—The Secretary may
17 make a grant under subsection (a) or (l) only if the appli-
18 cant for the grant submits an application to the Secretary
19 that—

20 “(1) contains any agreements, assurances, and
21 information required in this section with respect to
22 the grant; and

23 “(2) is in such form, is made in such manner,
24 and contains such other agreements, assurances, and
25 information as the Secretary determines to be nec-

1 essary to carry out the purpose for which the grant
2 is to be provided.

3 “(n) DEFINITIONS.—For purposes of this section:

4 “(1) The term ‘designated population’ means
5 individuals described in subsection (b)(1)(C)(ii).

6 “(2) The term ‘primary health services’ includes
7 preventive health services.

8 “(3) The term ‘qualified health service area’
9 means a geographic area described in subsection (b).

10 “(o) AUTHORIZATION OF APPROPRIATIONS.—

11 “(1) PLANNING FOR PROJECTS.—For the pur-
12 pose of grants under subsection (l), there is author-
13 ized to be appropriated \$5,000,000 for fiscal year
14 1995, to remain available until expended.

15 “(2) OPERATION OF PROJECTS.—For the pur-
16 pose of grants under subsection (a), there is author-
17 ized to be appropriated an aggregate \$10,000,000
18 for the fiscal years 1996 through 1999.”.

19 **PART 3—COMMUNITY HEALTH NETWORKS**

20 **SEC. 1421. QUALIFICATIONS FOR COMMUNITY HEALTH** 21 **NETWORKS.**

22 (a) COMMUNITY HEALTH NETWORK DEFINED.—For
23 purposes of part 7 of subtitle B of title I of Employee
24 Retirement Income Security Act of 1974 and this Act,

1 added by section 1211(a) of this title, the term “commu-
2 nity health network” means an arrangement that—

3 (1) is organized by health care providers (in-
4 cluding medical practitioners), community groups, or
5 both, and such other organizations as may be des-
6 ignated by the arrangement, to provide health care
7 services to an enrolled population in a service area,

8 (2) provides to its enrollees at least the benefits
9 included in standard coverage (consistent with sec-
10 tion 1102(c)),

11 (3) receives payment for such services on a pro-
12 spective capitated basis, which may vary only by
13 family composition, geographic area, and age,

14 (4) meets the requirements of subsection (b)
15 (relating to public accountability),

16 (5) meets the requirements of subsection (c)
17 (relating to coordination and integration of care),

18 (6) meets the requirements of subsection (d) to
19 the extent the arrangement is organized as a non-
20 profit entity, and

21 (7) meets the requirements of section 707 of
22 the Employee Retirement Income Security Act of
23 1974 (relating to maintenance of reserves), added by
24 section 1211.

1 (b) PUBLIC ACCOUNTABILITY REQUIREMENTS.—The
 2 public accountability requirements of this subsection, with
 3 respect to a network, are as follows:

4 (1) PERFORMANCE MEASURES.—The network
 5 must establish and implement procedures for devel-
 6 oping, compiling, evaluating, and reporting perform-
 7 ance measures, statistics, and other information
 8 on—

9 (A) the cost and financial performance of
 10 network operations,

11 (B) the service utilization patterns of en-
 12 rollees,

13 (C) the availability, accessibility, and ac-
 14 ceptability of health care services to enrollees,

15 (D) ownership and governance of the net-
 16 work, and

17 (E) demographic characteristics of enroll-
 18 ees, and

19 Such information shall be published annually and
 20 disseminated to enrollees and the public.

21 (2) QUALITY ASSURANCE PROGRAM.—The net-
 22 work must have an organizational arrangement for
 23 an ongoing quality assurance program for all health
 24 services it provides which—

25 (A) stresses health outcomes,

(B) to the maximum extent possible, relies primarily on evaluating and comparing practice patterns (rather than routine case-by-case review) to identify problems,

(C) provides review by physicians and other health professionals of the outcomes and process followed in the provision of health services, and

(D) makes the coverage and utilization review requirements of the plan, and the standards applied for such review, available to providers and the public.

(3) ENROLLMENT.—The network does not expel or refuse to enroll any applicant or limit coverage of services included in standard coverage for any applicant because of the health status or requirements for health services.

(4) CREDENTIALING.—The network must develop and implement a process for the credentialing (and renewal of credentials) of network providers (including practitioners).

(5) GRIEVANCE PROCESS.—The network must have an enrollee complaint and grievance resolution process which shall meet any requirements of applicable law.

1 (c) COORDINATION AND INTEGRATION OF CARE RE-
2 QUIREMENTS.—The coordination and integration of care
3 requirements of this subsection, with respect to a network,
4 are as follows:

5 (1) COORDINATION AND INTEGRATION OF
6 CARE.—The network must establish and implement
7 mechanisms for coordinating the delivery of care
8 across provider settings and over time, including at
9 least mechanisms for—

10 (A) linking patient registration and medi-
11 cal record information so that it is accessible to
12 all parts of the network and, consistent with
13 State law, assures the confidentiality of patient
14 information,

15 (B) assisting enrollees to obtain necessary
16 care, including preventive services, and

17 (C) coordinating the services furnished to
18 an enrollee when more than one practitioner or
19 provider is involved.

20 (2) OUT-OF-AREA COVERAGE.—The network
21 must provide care within a defined service area es-
22 tablished by the arrangement and must provide for
23 reimbursement for standard coverage (consistent
24 with section 1102(c)) for enrollees who are tempo-
25 rarily outside such area.

(3) COMMON MALPRACTICE POLICY.—Providers (including practitioners) that provide standard coverage to network enrollees must be covered for malpractice in accordance with documented criteria established by the arrangement.

(4) RECORD KEEPING.—The network must use a unified patient registration system and medical records system that is accessible to all parts of the network and assures confidentiality of patient information, consistent with State law.

(d) REQUIREMENTS FOR NETWORKS ORGANIZED AS NONPROFIT ENTITIES.—The requirements of this subsection, with respect to a network, are as follows:

(1) COMMUNITY HEALTH STATUS IMPROVEMENT PROCESS.—The network develops and implements a community health status improvement process, in cooperation with other existing networks and community organizations from the same service area, that—

(A) provides for an assessment of community health status that identifies important health status problems in such area,

(B) implements measures to address such problems, and

1 (C) evaluates the efficiency and effective-
 2 ness of such measures in addressing such prob-
 3 lems.

4 The results of evaluations made pursuant to sub-
 5 paragraph (C) shall be made publicly available on at
 6 least an annual basis.

7 (2) ENROLLMENT.—The network enrolls indi-
 8 viduals who are broadly representative of the various
 9 age, social, and income groups within the area it
 10 serves.

11 **Subtitle F—Improved Access to** 12 **Rural Health Services**

13 **PART 1—ESTABLISHMENT OF RURAL EMER-** 14 **GENCY ACCESS CARE HOSPITALS UNDER** 15 **MEDICARE**

16 **SEC. 1501. RURAL EMERGENCY ACCESS CARE HOSPITALS** 17 **DESCRIBED.**

18 Section 1861 of the Social Security Act (42 U.S.C.
 19 1395x) is amended by adding at the end the following new
 20 subsection:

21 “Rural Emergency Access Care Hospital; Rural
 22 Emergency Access Care Hospital Services

23 “(oo)(1) The term ‘rural emergency access care hos-
 24 pital’ means, for a fiscal year, a facility with respect to
 25 which the Secretary finds the following:

1 “(A) The facility is located in a rural area (as
2 defined in section 1886(d)(2)(D)).

3 “(B) The facility was a hospital under this title
4 at any time during the 5-year period that ends on
5 the date of the enactment of this subsection.

6 “(C) The facility is in danger of closing due to
7 low inpatient utilization rates and negative operating
8 losses, and the closure of the facility would limit the
9 access of individuals residing in the facility’s service
10 area to emergency services.

11 “(D) The facility has entered into (or plans to
12 enter into), with a hospital with a participation
13 agreement in effect under section 1866(a), and
14 under such agreement the hospital shall accept pa-
15 tients transferred to the hospital from the facility
16 and receives data from and transmits data to the fa-
17 cility.

18 “(E) There is a practitioner who is qualified to
19 provide advanced cardiac life support services (as de-
20 termined by the State in which the facility is lo-
21 cated) on-site at the facility on a 24-hour basis.

22 “(F) A physician is available on-call to provide
23 emergency medical services on a 24-hour basis.

1 “(G) The facility meets such staffing require-
2 ments as would apply under section 1861(e) to a
3 hospital located in a rural area, except that—

4 “(i) the facility need not meet hospital
5 standards relating to the number of hours dur-
6 ing a day, or days during a week, in which the
7 facility must be open, except insofar as the fa-
8 cility is required to provide emergency care on
9 a 24-hour basis under subparagraphs (E) and
10 (F); and

11 “(ii) the facility may provide any services
12 otherwise required to be provided by a full-time,
13 on-site dietician, pharmacist, laboratory techni-
14 cian, medical technologist, or radiological tech-
15 nologist on a part-time, off-site basis.

16 “(H) The facility meets the requirements appli-
17 cable to clinics and facilities under subparagraphs
18 (C) through (J) of paragraph (2) of section
19 1861(aa) and of clauses (ii) and (iv) of the second
20 sentence of such paragraph (or, in the case of the
21 requirements of subparagraph (E), (F), or (J) of
22 such paragraph, would meet the requirements if any
23 reference in such subparagraph to a ‘nurse practi-
24 tioner’ or to ‘nurse practitioners’ was deemed to be
25 a reference to a ‘nurse practitioner or nurse’ or to

‘nurse practitioners or nurses’), except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a ‘physician’ is a reference to a physician as defined in section 1861(r)(1).

“(2) The term ‘rural emergency access care hospital services’ means medical and other health services furnished by a rural emergency access care hospital.”.

SEC. 1502. COVERAGE OF AND PAYMENT FOR SERVICES.

(a) COVERAGE UNDER PART B.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking “and” at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting “; and”; and

(3) by adding at the end the following new subparagraph:

“(K) rural emergency access care hospital services (as defined in section 1861(o)(2)).”.

(b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) of the Social Security Act (42 U.S.C. 1395l(a)(6)) is

1 amended by striking “services,” and inserting “serv-
2 ices and rural emergency access care hospital serv-
3 ices,”.

4 (2) PAYMENT METHODOLOGY DESCRIBED.—
5 Section 1834(g) of such Act (42 U.S.C. 1395m(g))
6 is amended—

7 (A) in the heading, by striking “SERV-
8 ICES” and inserting “SERVICES AND RURAL
9 EMERGENCY ACCESS CARE HOSPITAL SERV-
10 ICES”; and

11 (B) in paragraph (1), by striking “during
12 a year before 1993” and inserting “during a
13 year before the prospective payment system de-
14 scribed in paragraph (2) is in effect”;

15 (C) in paragraph (1), by adding at the end
16 the following:

17 “The amount of payment shall be determined under
18 either method without regard to the amount of the
19 customary or other charge.”;

20 (D) in paragraph (2), by striking “Janu-
21 ary 1, 1993,” and inserting “January 1,
22 1996,”; and

23 (E) by adding at the end the following new
24 paragraph:

“(3) APPLICATION OF METHODS TO PAYMENT FOR RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.”.

SEC. 1503. EFFECTIVE DATE.

The amendments made by sections 1501 and 1502 shall apply to fiscal years beginning on or after October 1, 1994.

**PART 2—RURAL MEDICAL EMERGENCIES AIR
TRANSPORT**

**SEC. 1511. GRANTS TO STATES REGARDING AIRCRAFT FOR
TRANSPORTING RURAL VICTIMS OF MEDICAL
EMERGENCIES.**

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d–51 et seq.) is amended by adding at the end thereof the following new section:

**“SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL
VICTIMS OF MEDICAL EMERGENCIES.**

“(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims

1 of medical emergencies in rural areas with access to treat-
2 ments for the injuries or other conditions resulting from
3 such emergencies.

4 “(b) APPLICATION AND PLAN.—

5 “(1) APPLICATION.—To be eligible to receive a
6 grant under subsection (a), a State shall prepare
7 and submit to the Secretary an application in such
8 form, made in such manner, and containing such
9 agreements, assurances, and information, including
10 a State plan as required in paragraph (2), as the
11 Secretary determines to be necessary to carry out
12 this section.

13 “(2) STATE PLAN.—An application submitted
14 under paragraph (1) shall contain a State plan that
15 shall—

16 “(A) describe the intended uses of the
17 grant proceeds and the geographic areas to be
18 served;

19 “(B) demonstrates that the geographic
20 areas to be served, as described under subpara-
21 graph (A), are rural in nature;

22 “(C) demonstrate that there is a lack of
23 facilities available and equipped to deliver ad-
24 vanced levels of medical care in the geographic
25 areas to be served;

1 “(D) demonstrate that in utilizing the
2 grant proceeds for the establishment or en-
3 hancement of air medical services the State
4 would be making a cost-effective improvement
5 to existing ground-based or air emergency medi-
6 cal service systems;

7 “(E) demonstrate that the State will not
8 utilize the grant proceeds to duplicate the capa-
9 bilities of existing air medical systems that are
10 effectively meeting the emergency medical needs
11 of the populations they serve;

12 “(F) demonstrate that in utilizing the
13 grant proceeds the State is likely to achieve a
14 reduction in the morbidity and mortality rates
15 of the areas to be served, as determined by the
16 Secretary;

17 “(G) demonstrate that the State, in utiliz-
18 ing the grant proceeds, will—

19 “(i) maintain the expenditures of the
20 State for air and ground medical transport
21 systems at a level equal to not less than
22 the level of such expenditures maintained
23 by the State for the fiscal year preceding
24 the fiscal year for which the grant is re-
25 ceived; and

“(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

“(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan;

“(I) contain such other information as the Secretary may determine appropriate.

“(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

“(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

“(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

1 “(d) STATE ADMINISTRATION AND USE OF
2 GRANT.—

3 “(1) IN GENERAL.—The Secretary may not
4 make a grant to a State under subsection (a) unless
5 the State agrees that such grant will be adminis-
6 tered by the State agency with principal responsibil-
7 ity for carrying out programs regarding the provi-
8 sion of medical services to victims of medical emer-
9 gencies or trauma.

10 “(2) PERMITTED USES.—A State may use
11 amounts received under a grant awarded under this
12 section to award subgrants to public and private en-
13 tities operating within the State.

14 “(3) OPPORTUNITY FOR PUBLIC COMMENT.—
15 The Secretary may not make a grant to a State
16 under subsection (a) unless that State agrees that,
17 in developing and carrying out the State plan under
18 subsection (b)(2), the State will provide public notice
19 with respect to the plan (including any revisions
20 thereto) and facilitate comments from interested
21 persons.

22 “(e) NUMBER OF GRANTS.—The Secretary shall
23 award grants under this section to not less than 7 States.

24 “(f) REPORTS.—

1 “(1) REQUIREMENT.—A State that receives a
2 grant under this section shall annually (during each
3 year in which the grant proceeds are used) prepare
4 and submit to the Secretary a report that shall con-
5 tain—

6 “(A) a description of the manner in which
7 the grant proceeds were utilized;

8 “(B) a description of the effectiveness of
9 the air medical transport programs assisted
10 with grant proceeds; and

11 “(C) such other information as the Sec-
12 retary may require.

13 “(2) TERMINATION OF FUNDING.—In reviewing
14 reports submitted under paragraph (1), if the Sec-
15 retary determines that a State is not using amounts
16 provided under a grant awarded under this section
17 in accordance with the State plan submitted by the
18 State under subsection (b), the Secretary may termi-
19 nate the payment of amounts under such grant to
20 the State until such time as the Secretary deter-
21 mines that the State comes into compliance with
22 such plan.

23 “(g) DEFINITION.—As used in this section, the term
24 ‘rural areas’ means geographic areas that are located out-

1 side of standard metropolitan statistical areas, as identi-
 2 fied by the Secretary.

3 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
 4 are authorized to be appropriated to make grants under
 5 this section, \$15,000,000 for fiscal year 1994, and such
 6 sums as may be necessary for each of the fiscal years 1996
 7 and 1997.”.

8 **PART 3—EMERGENCY MEDICAL SERVICES**

9 **AMENDMENTS**

10 **SEC. 1521. ESTABLISHMENT OF OFFICE OF EMERGENCY** 11 **MEDICAL SERVICES.**

12 Title XII of the Public Health Service Act (42 U.S.C.
 13 300d et seq.) is amended—

14 (1) in the heading for the title, by striking
 15 “TRAUMA CARE” and inserting “EMERGENCY
 16 MEDICAL SERVICES”;

17 (2) in the heading for part A, by striking
 18 “GENERAL” and all that follows and inserting
 19 “GENERAL AUTHORITIES AND DUTIES”; and

20 (3) by amending section 1201 to read as fol-
 21 lows:

22 **“SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY** 23 **MEDICAL SERVICES.**

24 “(a) IN GENERAL.—The Secretary shall establish an
 25 office to be known as the Office of Emergency Medical

1 Services, which shall be headed by a director appointed
2 by the Secretary. The Secretary shall carry out this title
3 acting through the Director of such Office.

4 “(b) GENERAL AUTHORITIES AND DUTIES.—With
5 respect to emergency medical services (including trauma
6 care), the Secretary shall—

7 “(1) conduct and support research, training,
8 evaluations, and demonstration projects;

9 “(2) foster the development of appropriate,
10 modern systems of such services through the sharing
11 of information among agencies and individuals in-
12 volved in the study and provision of such services;

13 “(3) sponsor workshops and conferences;

14 “(4) as appropriate, disseminate to public and
15 private entities information obtained in carrying out
16 paragraphs (1) through (4);

17 “(5) provide technical assistance to State and
18 local agencies;

19 “(6) coordinate activities of the Department of
20 Health and Human Services; and

21 “(7) as appropriate, coordinate activities of
22 such Department with activities of other Federal
23 agencies.

24 “(c) CERTAIN REQUIREMENTS.—With respect to
25 emergency medical services (including trauma care), the

1 Secretary shall ensure that activities under subsection (b)
2 are carried out regarding—

3 “(1) maintaining an adequate number of health
4 professionals with expertise in the provision of the
5 services, including hospital-based professionals and
6 prehospital-based professionals;

7 “(2) developing, periodically reviewing, and re-
8 vising as appropriate, in collaboration with appro-
9 priate public and private entities, guidelines for the
10 provision of such services (including, for various typ-
11 ical circumstances, guidelines on the number and va-
12 riety of professionals, on equipment, and on train-
13 ing);

14 “(3) the appropriate use of available tech-
15 nologies, including communications technologies; and

16 “(4) the unique needs of underserved inner-city
17 areas and underserved rural areas.

18 “(d) GRANTS, COOPERATIVE AGREEMENTS, AND
19 CONTRACTS.—In carrying out subsections (b) and (c), the
20 Secretary may make grants and enter into cooperative
21 agreements and contracts.

22 “(e) DEFINITIONS.—For purposes of this part:

23 “(1) The term ‘hospital-based professional’
24 means a health professional (including an allied
25 health professional) who has expertise in providing

one or more emergency medical services and who normally provides the services at a medical facility.

“(2) The term ‘prehospital-based professional’ means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at the site of the medical emergency or during transport to a medical facility.”.

SEC. 1522. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

(a) TECHNICAL AMENDMENTS TO FACILITATE ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(A) by redesignating section 1239 as section 1235;

(B) by redesignating sections 1231 and 1233 as sections 1236 and 1237, respectively; and

(C) by redesignating sections 1211 through 1222 as sections 1221 through 1232, respectively.

(2) MODIFICATIONS IN FORMAT OF TITLE
 XII.—Title XII of the Public Health Service Act, as
 amended by paragraph (1) of this subsection, is
 amended—

(A) by striking “PART B” and all that fol-
 low through “STATE PLANS” and inserting the
 following:

“Subpart II—Formula Grants With Respect to
 Modifications of State Plans”;

(B) by striking “PART C—GENERAL PRO-
 VISIONS” and inserting the following:

“Subpart III—General Provisions”;

(C) by redesignating sections 1202 and
 1203 as sections 1211 and 1212, respectively;
 and

(D) by inserting before section 1211 (as so
 redesignated) the following:

“PART B—TRAUMA CARE

“Subpart I—Advisory Council; Clearinghouse”.

(b) STATE OFFICES.—Title XII of the Public Health
 Service Act, as amended by subsection (a) of this section,
 is amended by inserting after section 1201 the following
 new section:

1 **"SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL**
2 **SERVICES.**

3 “(a) PROGRAM OF GRANTS.—The Secretary may
4 make grants to States for the purpose of improving the
5 availability and quality of emergency medical services
6 through the operation of State offices of emergency medi-
7 cal services.

8 “(b) REQUIREMENT OF MATCHING FUNDS.—

9 “(1) IN GENERAL.—The Secretary may not
10 make a grant under subsection (a) unless the State
11 involved agrees, with respect to the costs to be in-
12 curred by the State in carrying out the purpose de-
13 scribed in such subsection, to provide non-Federal
14 contributions toward such costs in an amount that—

15 “(A) for the first fiscal year of payments
16 under the grant, is not less than \$1 for each \$3
17 of Federal funds provided in the grant;

18 “(B) for any second fiscal year of such
19 payments, is not less than \$1 for each \$1 of
20 Federal funds provided in the grant; and

21 “(C) for any third fiscal year of such pay-
22 ments, is not less than \$3 for each \$1 of Fed-
23 eral funds provided in the grant.

24 “(2) DETERMINATION OF AMOUNT OF NON-
25 FEDERAL CONTRIBUTION.—

1 “(A) Subject to subparagraph (B), non-
2 Federal contributions required in paragraph (1)
3 may be in cash or in kind, fairly evaluated, in-
4 cluding plant, equipment, or services. Amounts
5 provided by the Federal Government, or serv-
6 ices assisted or subsidized to any significant ex-
7 tent by the Federal Government, may not be in-
8 cluded in determining the amount of such non-
9 Federal contributions.

10 “(B) The Secretary may not make a grant
11 under subsection (a) unless the State involved
12 agrees that—

13 “(i) for the first fiscal year of pay-
14 ments under the grant, 100 percent or less
15 of the non-Federal contributions required
16 in paragraph (1) will be provided in the
17 form of in-kind contributions;

18 “(ii) for any second fiscal year of such
19 payments, not more than 50 percent of
20 such non-Federal contributions will be pro-
21 vided in the form of in-kind contributions;
22 and

23 “(iii) for any third fiscal year of such
24 payments, such non-Federal contributions
25 will be provided solely in the form of cash.

1 “(c) CERTAIN REQUIRED ACTIVITIES.—The Sec-
 2 retary may not make a grant under subsection (a) unless
 3 the State involved agrees that activities carried out by an
 4 office operated pursuant to such subsection will include—

5 “(1) coordinating the activities carried out in
 6 the State that relate to emergency medical services;

7 “(2) activities regarding the matters described
 8 in paragraphs (1) through (4) section 1201(b);

9 “(3) identifying Federal and State programs re-
 10 garding emergency medical services and providing
 11 technical assistance to public and nonprofit private
 12 entities regarding participation in such programs.

13 “(d) REQUIREMENT REGARDING ANNUAL BUDGET
 14 FOR OFFICE.—The Secretary may not make a grant
 15 under subsection (a) unless the State involved agrees that,
 16 for any fiscal year for which the State receives such a
 17 grant, the office operated pursuant to subsection (a) will
 18 be provided with an annual budget of not less than
 19 \$50,000.

20 “(e) CERTAIN USES OF FUNDS.—

21 “(1) RESTRICTIONS.—The Secretary may not
 22 make a grant under subsection (a) unless the State
 23 involved agrees that—

24 “(A) if research with respect to emergency
 25 medical services is conducted pursuant to the

grant, not more than 10 percent of the grant will be expended for such research; and

“(B) the grant will not be expended to provide emergency medical services (including providing cash payments regarding such services).

“(2) ESTABLISHMENT OF OFFICE.—Activities for which a State may expend a grant under subsection (a) include paying the costs of establishing an office of emergency medical services for purposes of such subsection.

“(f) REPORTS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees to submit to the Secretary reports containing such information as the Secretary may require regarding activities carried out under this section by the State.

“(g) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.”.

SEC. 1523. PROGRAMS FOR RURAL AREAS.

(a) IN GENERAL.—Title XII of the Public Health Service Act, as amended by section 1522, is amended—

1 (1) by transferring section 1204 to part A;

2 (2) by redesignating such section as section
3 1203;

4 (3) by inserting such section after section 1202;
5 and

6 (4) in section 1203 (as so redesignated)—

7 (A) by redesignating subsection (c) as sub-
8 section (d); and

9 (B) by inserting after subsection (b) the
10 following new subsection:

11 “(c) DEMONSTRATION PROGRAM REGARDING TELE-
12 COMMUNICATIONS.—

13 “(1) LINKAGES FOR RURAL FACILITIES.—

14 Projects under subsection (a)(1) shall include dem-
15 onstration projects to establish telecommunications
16 between rural medical facilities and medical facilities
17 that have expertise or equipment that can be utilized
18 by the rural facilities through the telecommuni-
19 cations.

20 “(2) MODES OF COMMUNICATION.—The Sec-
21 retary shall ensure that the telecommunications
22 technologies demonstrated under paragraph (1) in-
23 clude interactive video telecommunications, static
24 video imaging transmitted through the telephone

1 system, and facsimiles transmitted through such sys-
2 tem.”.

3 (b) CONFORMING AMENDMENT.—Section 1203 of the
4 Public Health Service Act, as redesignated by subsection
5 (a)(2) of this section, is amended in the heading for the
6 section by striking “**ESTABLISHMENT**” and all that fol-
7 lows and inserting “**PROGRAMS FOR RURAL AREAS.**”.

8 **SEC. 1524. FUNDING.**

9 Title XII of the Public Health Service Act, as amend-
10 ed by the preceding provisions of this title, is amended—

11 (1) by redesignating parts C through F as parts
12 D through G, respectively;

13 (2) by inserting after subpart III of part B the
14 following:

15 “PART C—FUNDING”;

16 (3) by transferring section 1239 to part C (as
17 so added); and

18 (4) in such section, by striking subsections (a)
19 and (b) and inserting the following:

20 “(a) EMERGENCY MEDICAL SERVICES GEN-
21 ERALLY.—

22 “(1) IN GENERAL.—For the purpose of carry-
23 ing out section 1201 other than with respect to trau-
24 ma care, there are authorized to be appropriated
25 \$2,000,000 for fiscal year 1995, and such sums as

1 may be necessary for each of the fiscal years 1996
2 and 1997.

3 “(2) STATE OFFICES.—For the purpose of car-
4 rying out section 1202, there are authorized to be
5 appropriated \$3,000,000 for fiscal year 1995, and
6 such sums as may be necessary for each of the fiscal
7 years 1996 and 1997.

8 “(3) CERTAIN TELECOMMUNICATIONS DEM-
9 ONSTRATIONS.—For the purpose of carrying out sec-
10 tion 1203(c), there are authorized to be appro-
11 priated \$10,000,000 for fiscal year 1995 and such
12 sums as may be necessary for each of the fiscal
13 years 1996 and 1997.

14 “(b) TRAUMA CARE AND CERTAIN OTHER ACTIVI-
15 TIES.—

16 “(1) IN GENERAL.—For the purpose of carry-
17 ing out part B, section 1201 with respect to trauma
18 care, and section 1203 (other than subsection (c) of
19 such section), there are authorized to be appro-
20 priated \$60,000,000 for fiscal year 1995, and such
21 sums as may be necessary for each of the fiscal
22 years 1996 and 1997.

23 “(2) ALLOCATION OF FUNDS BY SECRETARY.—

24 “(A) For the purpose of carrying out sub-
25 part I of part B, section 1201 with respect to

1 trauma care, and section 1203 (other than sub-
2 section (c) of such section), the Secretary shall
3 make available 10 percent of the amounts ap-
4 propriated for a fiscal year under paragraph
5 (1).

6 “(B) For the purpose of carrying out sec-
7 tion 1203 (other than subsection (c) of such
8 section), the Secretary shall make available 10
9 percent of the amounts appropriated for a fiscal
10 year under paragraph (1).

11 “(C)(i) For the purpose of making allot-
12 ments under section 1221(a), the Secretary
13 shall, subject to subsection (c), make available
14 80 percent of the amounts appropriated for a
15 fiscal year under paragraph (1).

16 “(ii) Amounts paid to a State under sec-
17 tion 1221(a) for a fiscal year shall, for the pur-
18 poses for which the amounts were paid, remain
19 available for obligation until the end of the fis-
20 cal year immediately following the fiscal year
21 for which the amounts were paid.”.

22 **SEC. 1525. CONFORMING AMENDMENTS.**

23 Title XII of the Public Health Service Act, as amend-
24 ed by the preceding provisions of this title, is amended—

1 (1) in section 1203(b), by striking “1214(c)(1)”
2 and inserting “1224(c)(1)”;

3 (2) in section 1211(b)(3), by striking “1213(c)”
4 and inserting “1223(c)”;

5 (3) in section 1221—

6 (A) in subsection (a)—

7 (i) by striking “1218” and inserting
8 “1228”; and

9 (ii) by striking “1217” and inserting
10 “1227”; and

11 (B) in subsection (b)—

12 (i) by striking “1233” and inserting
13 “1237”; and

14 (ii) by striking “1213” and inserting
15 “1223”;

16 (4) in section 1222—

17 (A) in subsection (a)—

18 (i) in paragraph (1), by striking
19 “1211(a)” and inserting “1221(a)”;

20 (ii) in paragraph (2)(A), by striking
21 “1211(c)” and inserting “1221(c)”;

22 (B) in subsection (b), by striking
23 “1211(a)” and inserting “1221(a)”;

24 (5) in section 1223—

1 (A) in subsection (a), by striking
2 “1211(b)” and inserting “1221(b)”;

3 (B) in subsection (b)—

4 (i) in paragraph (1), by striking
5 “1211(a)” and inserting “1221(a)”;

6 (ii) in paragraph (3), by striking
7 “1211(a)” and inserting “1221(a)”;

8 (C) in subsection (d), by striking
9 “1211(a)” and inserting “1221(a)”;

10 (6) in section 1224—

11 (A) in each of subsections (a) through (c),
12 by striking “1211(a)” and inserting “1221(a)”;
13 and

14 (B) in subsection (b), by striking
15 “1213(a)(7)” and inserting “1223(a)(7)”;

16 (7) in section 1225—

17 (A) in subsection (a)—

18 (i) by striking “1211(a)” and insert-
19 ing “1221(a)”;

20 (ii) by striking “1233” and inserting
21 “1237”;

22 (B) in subsection (b), by striking
23 “1211(b)” and inserting “1221(b)”;

(8) in section 1226; in each of subsections (a) through (c), by striking “1211(a)” and inserting “1221(a)”;

(9) in section 1227—

(A) by striking “1211(a)” and inserting “1221(a)”;

(B) by striking “1214” and inserting “1224”;

(10) in section 1228—

(A) in each of subsections (a) through (c), by striking “1211(a)” each place such term appears and inserting “1221(a)”;

(B) in subsection (b), in each of paragraphs (2)(A) and (3)(A), by striking “1232(a)” and inserting “1239(a)”;

(C) in subsection (c)(2)—

(i) by striking “1232(b)(3)” and inserting “1239(b)(3)”;

(ii) by striking “1217” and inserting “1227”;

(11) in section 1229(a), by striking “1211(a)” each place such term appears and inserting “1221(a)”;

(12) in section 1230(a), by striking “1211(a)”
each place such term appears and inserting
“1221(a)”;

(13) in section 1231—

(A) in each of subsections (a) and (b), by
striking “1211(a)” each place such term ap-
pears and inserting “1221(a)”;

(B) in each of subsections (a) and (b), by
striking “1211(b)” and inserting “1221(b)”;

(14) in section 1232, by striking “1211” and
inserting “1221”;

(15) in section 1236—

(A) in the matter preceding paragraph (1),
by striking “this title” and inserting “this
part”;

(B) in paragraph (1), by striking “1213”
and inserting “1223”;

(16) in section 1237—

(A) in each of subsections (a) and (b), by
striking “1211” each place such term appears
and inserting “1221”;

(B) in subsection (b)—

(i) by striking “part B” and inserting
“subpart II”;

(ii) by striking “1214(c)(1)” and inserting “1224(c)(1)”; and

(C) in subsection (c), by striking “1213” and inserting “1223”; and

(17) in section 1239(c)(1)—

(A) by striking “1211(a)” and inserting “1221(a)”; and

(B) by striking “1218(a)(2)” and inserting “1228(a)(2)”; and

(C) by striking “part B” and inserting “subpart II”.

SEC. 1526. EFFECTIVE DATE.

The amendments made by this part shall take effect October 1, 1994, or upon the date of the enactment of this Act, whichever occurs later.

PART 4—ADDITIONAL RURAL HEALTH CARE PROVISIONS

SEC. 1531. DEVELOPMENT OF COMMUNITY-OPERATED HEALTH PLANS IN RURAL AND FRONTIER AREAS.

(a) **COMMUNITY-OPERATED HEALTH PLANS.**—The Secretary of Health and Human Services (in this part referred to as the “Secretary”) may make grants to public and nonprofit private entities for the purpose of carrying

1 out projects to develop health plans to provide services ex-
2 clusively in rural and frontier areas.

3 (b) COMMUNITY INVOLVEMENT.—The Secretary may
4 make a grant under subsection (a) only if the applicant
5 involved meets the following conditions:

6 (1) In developing the proposal of the applicant
7 for a project under such subsection, the applicant
8 has consulted with the local governments of the geo-
9 graphic area to be served by the health plan devel-
10 oped through the project, with individuals who reside
11 in the area, and with a reasonable number and vari-
12 ety of health professionals who provide services in
13 the area.

14 (2) The applicant agrees that the principal legal
15 authority over the operation of the health plan will
16 be vested in individuals who reside in such geo-
17 graphic area.

18 (3) In the proposal the applicant specifies how
19 a full continuum of services will be provided.

20 (4) In the proposal the applicant specifies how
21 the proposed health plan will utilize existing health
22 care facilities in a manner that avoids unnecessary
23 duplication.

24 (c) USE OF FUNDS.—

1 (1) IN GENERAL.—Funds made available under
2 this section may be used for the following:

3 (A) To develop integrated health networks,
4 utilizing existing local providers and facilities
5 where appropriate, with community involve-
6 ment.

7 (B) For information systems, including
8 telecommunications.

9 (C) For transportation services.

10 (D) To develop rural emergency access
11 care hospitals (as defined in section
12 1861(o)(1) of the Social Security Act, as
13 added by section 1501).

14 (2) LIMITATIONS.—Funds made available under
15 this section shall not be used for the following:

16 (A) For a telecommunications system, un-
17 less the system is coordinated with, and does
18 not duplicate, such a system existing in the
19 area.

20 (B) For paying off existing debt.

21 (d) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated \$25,000,000 in each of
23 fiscal years 1996, 1997, and 1998 to carry out this sec-
24 tion.

1 **SEC. 1532. PRIMARY HEALTH CARE FOR MEDICALLY UN-**
2 **DERSERVED RURAL COMMUNITIES; IN-**
3 **CREASED CAPACITY OF HOSPITALS AND OUT-**
4 **PATIENT FACILITIES.**

5 (a) **IN GENERAL.**—The Secretary may make grants
6 to public and nonprofit private hospitals in medically un-
7 derserved rural communities, and to public and nonprofit
8 outpatient facilities in such communities, for the purpose
9 of carrying out projects to develop or increase the capacity
10 of the hospitals and facilities to provide primary health
11 services.

12 (b) **MEDICALLY UNDERSERVED RURAL COMMU-**
13 **NITY.**—For purposes of this section, the term “medically
14 underserved rural community” means—

15 (1) a rural area that has a substantial number
16 of individuals who are members of a medically un-
17 derserved population, as defined in section 330 of
18 the Public Health Service Act; or

19 (2) a rural area a significant portion of which
20 is a health professional shortage area designated
21 under section 332 of such Act.

22 (c) **CERTAIN EXPENDITURES.**—The purposes for
23 which the Secretary may authorize a grant under sub-
24 section (a) to be expended include the renovation of facili-
25 ties, the purchase of equipment, and the training of per-
26 sonnel.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—

2 (1) HOSPITALS.—There are authorized to be
3 appropriated \$50,000,000 in each of fiscal years
4 1996, 1997, and 1998 for the purpose of making
5 grants to hospitals under subsection (a).

6 (2) OUTPATIENT FACILITIES.—There are au-
7 thorized to be appropriated \$25,000,000 in each of
8 fiscal years 1996, 1997, and 1998 for the purpose
9 of making grants to outpatient facilities under sub-
10 section (a).

11 **SEC. 1533. INNOVATIVE APPROACHES TO DELIVERY OF**
12 **HEALTH SERVICES IN RURAL AREAS.**

13 (a) IN GENERAL.—The Secretary, acting through the
14 Administrator for Health Care Policy and Research, may
15 make grants to public and nonprofit private entities for
16 the purposes of conducting research and carrying out dem-
17 onstration projects to develop innovative approaches to the
18 delivery of health care in rural areas, such as the use of
19 telemedicine and the use of mobile delivery units.

20 (b) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated \$15,000,000 in each of
22 fiscal years 1996 through 2000 to carry out this section.

1 **SEC. 1534. TRAINING OF RURAL HEALTH PROFESSIONALS**
2 **OTHER THAN PHYSICIANS.**

3 (a) **FUNDING FOR PROGRAMS UNDER PUBLIC**
4 **HEALTH SERVICE ACT.**—With respect to programs of
5 title VII or VIII of the Public Health Service Act that
6 provide for the training of individuals as health profes-
7 sionals other than physicians, there are authorized to be
8 appropriated, in addition to amounts otherwise authorized
9 to be appropriated, \$50,000,000 in each of fiscal years
10 1996 through 2000 for the purpose of the Secretary carry-
11 ing out such programs through entities described in sub-
12 section (b).

13 (b) **ELIGIBILITY.**—With respect to a program re-
14 ferred to in subsection (a), an entity described in this sub-
15 section is an entity—

16 (1) that is eligible to receive grants or contracts
17 under the program (as provided in the applicable
18 provisions of title VII or VIII of the Public Health
19 Service Act); and

20 (2) a substantial number of whose designated
21 graduates are providing health services in a rural
22 area.

23 (c) **DEFINITION OF DESIGNATED GRADUATE.**—For
24 purposes of this section, the term “designated graduate”,
25 with respect to an entity, means an individual completing
26 the training involved during the 5-year period preceding

1 the fiscal year for which the entity is applying to receive
2 a grant or contract under the applicable program referred
3 to in subsection (a).

4 (d) RELATIONSHIP TO OTHER FUNDS.—The
5 amounts made available in subsection (a) for carrying out
6 programs referred to in such subsection are in addition
7 to any other amounts that are available for carrying out
8 the programs.

9 **SEC. 1535. GENERAL PROVISIONS.**

10 (a) APPLICATION FOR GRANT.—The Secretary may
11 make a grant under any section of this part only if an
12 application for the grant is submitted to the Secretary and
13 the application is in such form, is made in such manner,
14 and contains such agreements, assurances, and informa-
15 tion as the Secretary determines to be necessary to carry
16 out the program involved.

17 (b) TECHNICAL ASSISTANCE.—The Secretary may
18 provide technical assistance to recipients of grants or con-
19 tracts under this part with respect to the planning, devel-
20 opment, and operation of activities under the grants or
21 contracts.

1 Subtitle G—Assistance in Enrolling

2 Uninsured Children in Health

3 Insurance

4 SEC. 1601. ESTABLISHMENT OF STATE PROGRAMS.

5 (a) MEDICAID STATE PLAN REQUIREMENT.—Section
6 1902(a) of the Social Security Act (42 U.S.C. 1396a(a))
7 is amended—

8 (1) by striking “and” at the end of paragraph
9 (61);

10 (2) by striking the period at the end of para-
11 graph (62) and inserting “; and”; and

12 (3) by adding at the end the following new
13 paragraph:

14 “(63) provide for a State program furnishing
15 premium subsidies for needy children in accordance
16 with section 1932.”.

17 (b) STATE PROGRAMS FOR PREMIUM SUBSIDIES FOR
18 NEEDY CHILDREN.—Title XIX of the Social Security Act
19 (42 U.S.C. 1396 et seq.) is amended by redesignating sec-
20 tion 1931 as section 1932 and by inserting after section
21 1930 the following new section:

22 “STATE PREMIUM SUBSIDY PROGRAMS FOR NEEDY
23 CHILDREN

24 “SEC. 1932. (a) REQUIREMENT TO OPERATE STATE
25 PROGRAM.—

1 “(1) IN GENERAL.—A State with a State plan
2 approved under this title shall have in effect a pre-
3 mium subsidy program for furnishing premium sub-
4 sidy under subsection (b) to premium subsidy eligi-
5 ble children in the State in fiscal years beginning
6 with fiscal year 1998.

7 “(2) DESIGNATION OF STATE AGENCY.—A
8 State may designate any appropriate State agency to
9 administer the program under this section.

10 “(b) ASSISTANCE WITH PREMIUMS FOR STANDARD
11 HEALTH COVERAGE.—

12 “(1) ELIGIBILITY.—

13 “(A) IN GENERAL.—An eligible individual
14 who has been determined by a State to be a
15 premium subsidy eligible child (as defined in
16 paragraph (2)) shall be entitled to premium
17 subsidies in the amount determined under sub-
18 section (b).

19 “(B) PREMIUM SUBSIDY ELIGIBLE
20 CHILD.—For purposes of this section, the term
21 ‘premium subsidy eligible child’ means an indi-
22 vidual—

23 “(i) under 19 years of age,

24 “(ii) whose family has a family income
25 determined under this section which does

not exceed 185 percent (or such lesser percent as the Secretary may specify for a fiscal year, based on available funds during such fiscal year) of the poverty line, and

“(iii) except as provided in subparagraph (C), who is not otherwise eligible for medical assistance under the State plan (or would be eligible for such assistance on the basis of the plan in effect as of the date of the enactment of the Affordable Health Care Now Act of 1994).

“(C) ELIGIBILITY OF CHILDREN BECOMING ELIGIBLE FOR MEDICAID.—At the option of the State, a premium subsidy eligible child may include an individual who meets the requirements of clauses (i) and (ii) of subparagraph (B) and is eligible for medical assistance under the State plan if the individual was formerly a premium subsidy eligible child under subparagraph (B).

“(D) ADDITIONAL CHILDREN USING STATE-ONLY FUNDS.—Nothing in this section shall be construed as preventing a State, using its own funds and without any Federal financial

1 participation, from covering additional children
2 as premium subsidy eligible children.

3 “(c) AMOUNT OF PREMIUM SUBSIDY.—

4 “(1) IN GENERAL.—

5 “(A) IN GENERAL.—The premium subsidy
6 amount determined under this paragraph is a
7 monthly amount equal to the subsidy percent-
8 age of $\frac{1}{12}$ th of the lesser of—

9 “(i) the annual premium for certified
10 standard health coverage provided the
11 child, or

12 “(ii) the actuarial value of the stand-
13 ard option, nationwide service benefit plan
14 (taking into account cost sharing) made
15 available under chapter 89 of title, United
16 States Code for the year, adjusted to re-
17 flect a premium for a single child of the
18 age involved and adjusted to reflect the rel-
19 ative cost of premiums for health coverage
20 of premium subsidy eligible children in the
21 geographic area in which the child resides
22 compared to the national average.

23 “(B) SUBSIDY PERCENTAGE.—For pur-
24 poses of paragraph (1), an individual’s ‘subsidy
25 percentage’ means 100 percent reduced (but

not below zero percent) by 0.85 percentage points for each percentage point (or portion thereof) such individual's income equals or exceeds 100 percent of the poverty line.

“(d) PAYMENTS.—

“(1) IN GENERAL.—The amount of the premium subsidy available to a premium subsidy eligible child under subsection (b) shall be paid by the State in which the individual resides directly to the insurer that provides the coverage for the premium subsidy eligible child. Payments under the preceding sentence shall commence in the first month during which the individual is provided coverage and determined under this section to be a premium subsidy eligible child.

“(2) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium subsidy paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

“(e) ELIGIBILITY DETERMINATIONS.—

“(1) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State programs under this section with respect to

determining eligibility for premium subsidy, including requirements with respect to—

“(A) application procedures;

“(B) information verification procedures;

“(C) timeliness of eligibility determinations;

“(D) procedures for applicants to appeal adverse decisions; and

“(E) any other matters determined appropriate by the Secretary.

“(2) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under paragraph (1) shall include the following requirements:

“(A) FREQUENCY OF APPLICATIONS.—A State program shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person or by mail.

“(B) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under this section.

“(C) DISTRIBUTION OF APPLICATIONS.—A State program shall distribute applications for

1 assistance through employers and appropriate
2 public agencies.

3 “(D) REQUIREMENT TO SUBMIT REVISED
4 APPLICATION.—A State program shall, in ac-
5 cordance with regulations promulgated by the
6 Secretary, require individuals to submit revised
7 applications during a year to reflect changes in
8 estimated family incomes, including changes in
9 employment status of family members, during
10 the year. The State shall revise the amount of
11 any premium subsidy based on such a revised
12 application.

13 “(E) VERIFICATION.—A State program
14 shall provide for verification of the information
15 supplied in applications under this section.
16 Such verification may include examining return
17 information disclosed to the State for such pur-
18 pose under section 6103(l)(15) of the Internal
19 Revenue Code of 1986.

20 “(f) ADMINISTRATION OF STATE PROGRAMS.—

21 “(1) IN GENERAL.—The Secretary shall estab-
22 lish standards for States operating programs under
23 this section which ensure that such programs are op-
24 erated in a uniform manner with respect to applica-
25 tion procedures, data processing systems, and such

1 other administrative activities as the Secretary de-
2 termines to be necessary.

3 “(2) APPLICATION FORMS.—The Secretary
4 shall develop an application form for assistance
5 which shall—

6 “(A) be simple in form and understandable
7 to the average individual;

8 “(B) require the provision of information
9 necessary to make a determination as to wheth-
10 er an individual is a premium subsidy eligible
11 child including a declaration of estimated in-
12 come by the individual based, at the election of
13 the individual—

14 “(i) on multiplying by a factor of 4
15 the individual’s family income for the 3-
16 month period immediately preceding the
17 month in which the application is made, or

18 “(ii) on estimated income for the en-
19 tire year for which the application is sub-
20 mitted; and

21 “(C) require attachment of such docu-
22 mentation as deemed necessary by the Sec-
23 retary in order to ensure eligibility for assist-
24 ance.

1 “(3) OUTREACH ACTIVITIES.—A State operat-
2 ing a program under this section shall conduct such
3 outreach activities as the Secretary determines ap-
4 propriate.

5 “(4) EFFECTIVENESS OF ELIGIBILITY FOR PRE-
6 MIUM SUBSIDIES.—A determination by a State that
7 an individual is a premium subsidy eligible child
8 shall be effective for the calendar year for which
9 such determination is made unless a revised applica-
10 tion submitted under paragraph (2) indicates that
11 an individual is no longer eligible for premium sub-
12 sidies.

13 “(5) PENALTIES FOR MATERIAL MISREPRESENT-
14 TATIONS.—

15 “(A) IN GENERAL.—Any individual who
16 knowingly makes a material misrepresentation
17 of information in an application for assistance
18 under this section shall be liable to the Federal
19 Government for the amount of any premium
20 subsidy received by individual on the basis of a
21 misrepresentation and interest on such amount
22 at a rate specified by the Secretary, and shall,
23 in addition, be liable to the Federal Government
24 for \$2,000 or, if greater, 3 times the amount

1 any premium subsidy received by individual on
2 the basis of a misrepresentation.

3 “(B) COLLECTION OF PENALTY
4 AMOUNTS.—A State which receives an applica-
5 tion for assistance with respect to which a ma-
6 terial misrepresentation has been made shall
7 collect the penalty amount required under sub-
8 paragraph (A) and submit 50 percent of such
9 amount to the Secretary in a timely manner.

10 “(g) END-OF-YEAR RECONCILIATION FOR PREMIUM
11 SUBSIDY.—

12 “(1) IN GENERAL.—

13 “(A) REQUIREMENT TO FILE STATE-
14 MENT.—An individual who received premium
15 subsidies under this section from a State for
16 any month in a calendar year shall file with the
17 State an income reconciliation statement to ver-
18 ify the individual’s family income for the year.
19 Such a statement shall be filed at such time,
20 and contain such information, as the State may
21 specify in accordance with regulations promul-
22 gated by the Secretary.

23 “(B) NOTICE OF REQUIREMENT.—A State
24 shall provide a written notice of the require-
25 ment under subparagraph (A) at the end of the

1 year to an individual who received premium
2 subsidies under this part from such State in
3 any month during the year.

4 “(2) RECONCILIATION OF PREMIUM SUBSIDY
5 BASED ON ACTUAL INCOME.—

6 “(A) IN GENERAL.—Based on and using
7 the income reported in the reconciliation state-
8 ment filed under paragraph (1) with respect to
9 an individual, the State shall compute the
10 amount of premium subsidy that should have
11 been provided under this section with respect to
12 the individual for the year involved.

13 “(B) OVERPAYMENT OF ASSISTANCE.—If
14 the total amount of the premium subsidy pro-
15 vided was greater than the amount computed
16 under subparagraph (A), the individual is liable
17 to the State to pay an amount equal to the
18 amount of the excess payment. Any amount col-
19 lected by a State under this subparagraph shall
20 be submitted to the Secretary in a timely man-
21 ner.

22 “(C) UNDERPAYMENT OF ASSISTANCE.—If
23 the total amount of the premium subsidy pro-
24 vided was less than the amount computed under
25 subparagraph (A), the State shall pay to the in-

1 dividual an amount equal to the amount of the
2 deficit.

3 “(D) STATE OPTION.—A State may, in ac-
4 cordance with regulations promulgated by the
5 Secretary, establish a procedure under which
6 any overpayments or underpayments of pre-
7 mium subsidy determined under subparagraphs
8 (A) and (B) with respect to an individual for a
9 year may be collected or paid, as appropriate,
10 through adjustments to the premium subsidy
11 furnished to such individual in the succeeding
12 year.

13 “(3) VERIFICATION.—Each State may use such
14 information as it has available to verify income of in-
15 dividuals with applications filed under this section,
16 including return information disclosed to the state
17 for such purpose under section 6103(l)(15) of the
18 internal revenue code of 1986.

19 “(4) PENALTIES FOR FAILURE TO FILE.—In
20 the case of an individual who is required to file a
21 statement under this subsection in a year who fails
22 to file such a statement by such date as the Sec-
23 retary shall specify in regulations, the entire amount
24 of the premium subsidy provided in such year shall
25 be considered an excess amount under paragraph

(2)(A) and such individual shall not be eligible for premium subsidy assistance under this section until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this paragraph if the individual establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

“(5) PENALTIES FOR FALSE INFORMATION.—

Any individual who provides false information in a statement filed under paragraph (1) is subject to the same penalties as are provided under subsection (f)(5) for a misrepresentation of material fact described in such section.

“(h) SPECIAL RULES ON FEDERAL FINANCIAL PARTICIPATION.—

“(1) PREMIUM SUBSIDY.—In applying section 1903(a)(1) with respect to expenditures for premium subsidy (other than administrative expenses) under this section—

“(A) such expenditures shall be considered to be expenditures on medical assistance;

“(B) in the case of assistance for a premium subsidy eligible child not described in subsection (b)(1)(C), the Federal medical as-

1 sistance percentage is deemed to be 100 per-
2 cent, and

3 “(C) the total amount of Federal financial
4 participation with respect to any State for quar-
5 ters in any fiscal year shall not exceed the State
6 allotment under subsection (i)(2) for that year.

7 “(2) ADMINISTRATION EXPENSES.—The
8 amount of expenditures that may be taken into ac-
9 count in computing amounts that are payable to a
10 State under section 1903(a) (other than paragraph
11 (1)) with respect to the administration of the pro-
12 gram under this section may not exceed 3 percent of
13 the total expenditures

14 “(i) TOTAL FEDERAL BUDGET FOR PROGRAM; AL-
15 LOTMENTS TO STATES.—

16 “(1) TOTAL FEDERAL BUDGET.—

17 “(A) FISCAL YEARS 1998 through 2004.—
18 Subject to subparagraph (E)(iii), for purposes
19 of this section, the total Federal payments to
20 States under this section may not exceed the
21 following:

22 “(i) For fiscal year 1998, \$5.2 billion.

23 “(ii) For fiscal year 1999, \$7.0 bil-
24 lion.

1 “(iii) For fiscal year 2000, \$10.0 bil-
2 lion.

3 “(iv) For fiscal year 2001, \$11.3 bil-
4 lion.

5 “(v) For fiscal year 2002, \$15.3 bil-
6 lion.

7 “(vi) For fiscal year 2003, \$18.0 bil-
8 lion.

9 “(vii) For fiscal year 2004, \$22.4 bil-
10 lion.

11 “(B) SUBSEQUENT FISCAL YEARS.—For
12 purposes of this section, the total Federal budg-
13 et for State plans under this part for each fiscal
14 year after fiscal year 2004 is the total Federal
15 budget under this subsection for the preceding
16 fiscal year multiplied by the Secretary’s esti-
17 mate of the percentage increase in private sec-
18 tor health expenditures for the year.

19 “(2) ALLOTMENTS TO STATES.—

20 “(A) IN GENERAL.—The amount of a
21 State’s allotment under this section for a fiscal
22 year shall be equal to the product of—

23 “(i) the limit on the total amount of
24 Federal payments for the year under para-
25 graph (1)(A); and

“(ii) the State’s allotment percentage under subparagraph (B).

“(B) STATE ALLOTMENT PERCENTAGE.—

In subparagraph (A), a State’s allotment percentage for a fiscal year is equal to the percentage of all premium subsidy eligible children in the United States who are residents of the State (as estimated by the Secretary prior to the beginning of the fiscal year).

“(j) CERTIFIED STANDARD HEALTH COVERAGE DEFINED.—

“(1) IN GENERAL.—In this section, health insurance coverage is considered to provide certified standard health coverage if—

“(A) benefits under such coverage are provided within at least each of the required categories of benefits described in subparagraph (A) of paragraph (2) and consistent with such paragraph;

“(B) the actuarial value of the benefits meets the requirements of paragraph (3),

“(C) the benefits comply with the minimum requirements specified in paragraph (4), and

1 “(D) the benefits do not violate the anti-
2 discrimination rules described in paragraph (5).

3 “(2) REQUIRED CATEGORIES OF COVERED BEN-
4 EFITS.—

5 “(A) IN GENERAL.—The categories of cov-
6 ered benefits described in this subparagraph are
7 the types of benefits specified in subparagraphs
8 (A), (B), (C), (D), and (F) of paragraph (1),
9 and subparagraphs (E) and (F) of paragraph
10 (2), of section 8904(a) of title 5, United States
11 Code (relating to types of benefits required to
12 be in health insurance offered to Federal em-
13 ployees).

14 “(B) COVERAGE OF OFF-LABEL USE.—An
15 off-label use for a drug that has been found to
16 be safe and effective under section 505 of the
17 Federal Food, Drug, and Cosmetic Act shall be
18 covered if the medical indication for which it is
19 used is listed in one of the following 3 compen-
20 dia: the American Hospital Formulary Service-
21 Drug Information, the American Medical Asso-
22 ciation Drug Evaluations, and the United
23 States Pharmacopeia-Drug Information.

24 “(C) NO COVERAGE OF SPECIFIC TREAT-
25 MENT, PROCEDURES, OR CLASSES REQUIRED.—

1 Nothing in this subsection may be construed to
2 require the coverage of any specific procedure
3 or treatment or class of service in certified
4 standard health coverage under this Act or
5 through regulation.

6 “(3) STANDARD ACTUARIAL VALUE.—

7 “(A) IN GENERAL.—The actuarial value of
8 the benefits under standard coverage in a rat-
9 ing area meets the requirements of this para-
10 graph if such value is equivalent to the stand-
11 ard actuarial value described in subparagraph
12 (B) for the area, as adjusted for inflation under
13 subparagraph (D). The actuarial value of bene-
14 fits under standard coverage shall be deter-
15 mined using the standardized population and
16 set of standardized utilization and cost factors
17 described in subparagraph (C).

18 “(B) STANDARD ACTUARIAL VALUE DE-
19 SCRIBED.—The standard actuarial value de-
20 scribed in this subparagraph for coverage in a
21 geographic area is the actuarial value of bench-
22 mark coverage during 1994 in such area. Such
23 actuarial value shall be determined using the
24 standardized population and set of standardized

utilization and cost factors described in subparagraph (C).

“(C) ADJUSTMENTS FOR STANDARDIZED POPULATION, STANDARDIZED UTILIZATION AND COST FACTORS, AND GEOGRAPHIC AREA.—The adjustment under this subparagraph—

“(i) for a standardized population shall be made by not taking into account individuals 65 years of age or older, employees of the United States Postal Service, and retirees; and

“(ii) for a geographic area shall be made in a manner that reflects the ratio of the actuarial value of benchmark coverage in such geographic area (as adjusted under clause (i)) to such actuarial value for such benchmark coverage for the United States as a whole, taking into account standardized actuarial utilization and cost factors.

“(D) ADJUSTMENT FOR INFLATION.—

“(i) IN GENERAL.—The adjustment under this paragraph for a year (beginning with 1995) is the FEHBP national rolling increase percentage for the year involved,

1 compounded by such increase for each pre-
2 ceding year after 1994.

3 “(ii) FEHBP NATIONAL ROLLING IN-
4 CREASE PERCENTAGE.—For purposes of
5 this paragraph, the term “FEHBP na-
6 tional rolling increase percentage” means,
7 for a year, the 5-year average of the an-
8 nual national percentage increase in the
9 premiums for health plans offered under
10 the Federal Employees Health Benefits
11 Program (under chapter 89 of title 5,
12 United States Code) for the period ending
13 with the previous year. Such increase shall
14 be determined by the Secretary in con-
15 sultation with the Director of Office of
16 Personnel Management based on the best
17 information available.

18 “(4) MINIMUM REQUIREMENTS.—Benefits of-
19 fered under standard coverage within any category
20 shall be not less than the narrowest scope and short-
21 est duration of benefits within that category, in an
22 approved health benefits plan under chapter 89 of
23 title 5, United States Code, except that under such
24 coverage—

1 “(A) no cost-sharing may be imposed for
2 preventive services (as specified by the Sec-
3 retary); and

4 “(B) any cost-sharing imposed for other
5 items and services may only be nominal.

6 “(k) DEFINITIONS; DETERMINATIONS OF INCOME.—

7 For purposes of this part:

8 “(1) DETERMINATIONS OF INCOME.—

9 “(A) FAMILY INCOME.—The term ‘family
10 income’ means, with respect to an individual
11 who—

12 “(i) is not a dependent (as defined in
13 subparagraph (B)) of another individual,
14 the sum of the modified adjusted gross in-
15 comes (as defined in subparagraph (D))
16 for the individual, the individual’s spouse,
17 and dependents of the individual; or

18 “(ii) is a dependent of another indi-
19 vidual, the sum of the modified adjusted
20 gross incomes for the other individual, the
21 other individual’s spouse, and dependents
22 of the other individual.

23 “(B) DEPENDENT.—The term ‘dependent’
24 shall have the meaning given such term under

1 paragraphs (1) or (2) of section 152(a) of the
2 Internal Revenue Code of 1986.

3 “(C) SPECIAL RULE FOR FOSTER CHIL-
4 DREN.—For purposes of subparagraph (A), a
5 child who is placed in foster care by a State
6 agency shall not be considered a dependent of
7 another individual.

8 “(D) MODIFIED ADJUSTED GROSS IN-
9 COME.—The term ‘modified adjusted gross in-
10 come’ means adjusted gross income (as defined
11 in section 62(a) of the Internal Revenue Code
12 of 1986)—

13 “(i) determined without regard to sec-
14 tions 135, 162(l), 911, 931, and 933 of
15 such Code, and

16 “(ii) increased by—

17 “(I) the amount of interest re-
18 ceived or accrued by the individual
19 during the taxable year which is ex-
20 empt from tax, and

21 “(II) the amount of the social se-
22 curity benefits (as defined in section
23 86(d) of such Code) received during
24 the taxable year to the extent not in-

1 cluded in gross income under section
2 86 of such Code.

3 The determination under the preceding sen-
4 tence shall be made without regard to any car-
5 ryover or carryback.

6 “(2) ELIGIBLE INDIVIDUAL.—

7 “(A) IN GENERAL.—The term ‘eligible in-
8 dividual’ means an individual who is residing in
9 the United States and who is—

10 “(i) a citizen or national of the United
11 States; or

12 “(ii) an alien permanently residing in
13 the United States under color of law (as
14 defined in subparagraph (C)).

15 “(B) EXCLUSION.—The term ‘eligible indi-
16 vidual’ shall not include an individual who is an
17 inmate of a public institution (except as a pa-
18 tient of a medical institution).

19 “(C) ALIEN PERMANENTLY RESIDING IN
20 THE UNITED STATES UNDER COLOR OF LAW.—

21 The term ‘alien permanently residing in the
22 United States under color of law’ means an
23 alien lawfully admitted for permanent residence
24 (within the meaning of section 101(a)(20) of

1 the Immigration and Nationality Act), and in-
2 cludes any of the following:

3 “(i) An alien who is admitted as a ref-
4 ugee under section 207 of the Immigration
5 and Nationality Act.

6 “(ii) An alien who is granted asylum
7 under section 208 of such Act.

8 “(iii) An alien whose deportation is
9 withheld under section 243(h) of such Act.

10 “(iv) An alien who is admitted for
11 temporary residence under section 210,
12 210A, or 245A of such Act.

13 “(v) An alien who has been paroled
14 into the United States under section
15 212(d)(5) of such Act for an indefinite pe-
16 riod or who has been granted extended vol-
17 untary departure as a member of a nation-
18 ality group.

19 “(vi) An alien who is the spouse or
20 unmarried child under 21 years of age of
21 a citizen of the United States, or the par-
22 ent of such a citizen if the citizen is over
23 21 years of age, and with respect to whom
24 an application for adjustment to lawful
25 permanent residence is pending.

“(3) **POVERTY LINE.**—The term ‘poverty line’ means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) that—

“(A) in the case of a family of less than five individuals, is applicable to a family of the size involved; and

“(B) in the case of a family of more than four individuals, is applicable to a family of four persons.

“(4) **PREMIUM.**—Any reference to the term ‘premium’ includes a reference to premium equivalence for self-insured plans.”.

Subtitle H—Medicaid Reform

PART 1—STATE FLEXIBILITY IN THE MEDICAID PROGRAM: THE MEDICAL HEALTH ALLOWANCE PROGRAM

SEC. 1701. ESTABLISHMENT OF PROGRAM.

(a) **IN GENERAL.**—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 1601, is further amended—

(1) by redesignating section 1932 as section 1933; and

1 (2) by inserting after section 1931 the following
2 new section:

3 “STATE HEALTH ALLOWANCE PROGRAMS

4 “SEC. 1932. (a) TREATMENT OF EXPENDITURES
5 UNDER HEALTH ALLOWANCE PROGRAMS AS MEDICAL
6 ASSISTANCE UNDER STATE PLAN.—

7 “(1) IN GENERAL.—Notwithstanding any other
8 provision of this title, for purposes of determining
9 the amount to be paid to a State under section
10 1903(a)(1) for quarters in any fiscal year, amounts
11 expended by an eligible State (as described in sub-
12 section (b)) during the fiscal year under a State
13 health allowance program (as described in subsection
14 (c)) shall be included in the total amount expended
15 during the fiscal year as medical assistance under
16 the State plan (except as provided under paragraphs
17 (2) and (3) and under subsection (d)(1)(C)).

18 “(2) FEDERAL PAYMENT RESTRICTED TO
19 ACUTE CARE SERVICES.—No amounts expended
20 under a State health allowance program that are at-
21 tributable to medical assistance described in para-
22 graphs (4), (14), (15), (23), or (24) of section
23 1905(a) shall be included in the total amount ex-
24 pended as medical assistance under the State plan.

25 “(3) AMOUNT OF FEDERAL PAYMENT BASED
26 UPON UNUSED PREMIUM SUBSIDY PROGRAM ALLOT-

MENT.—In no case shall this subsection result in the total Federal payments to the State under this title (including payments attributable to this section and section 1923) for quarters in a fiscal year exceeding an amount equal to the difference between—

“(A) the State’s allotment for the premium subsidy program for children under section 1931(i)(2) for such fiscal year; and

“(B) the amount paid to the State for such program for such fiscal year.

“(b) ELIGIBILITY OF STATE.—A State is eligible for purposes of subsection (a) if the State submits (at such time and in such form as the Secretary may require) an application to the Secretary containing such information and assurances as the Secretary may require, including assurances that the State has adopted and is enforcing standards regarding quality assurance for group health plans participating in the State health allowance program, including standards regarding—

“(1) uniform reporting requirements for such plans relating to a minimum set of clinical data, patient satisfaction data, and other information that may be used by individuals to compare the quality of various plans; and

1 “(2) the establishment or designation of an en-
2 tity of the State government to collect the data de-
3 scribed in subparagraph (A) and to regularly report
4 such data to the Secretary.

5 “(c) STATE HEALTH ALLOWANCE PROGRAM DE-
6 SCRIBED.—

7 “(1) ENROLLMENT OF PARTICIPATING INDIVID-
8 UALS IN APPROVED GROUP HEALTH PLANS.—In this
9 section, a State health allowance program is a pro-
10 gram in effect in all the political subdivisions of the
11 State (except as provided in (c)) under which the
12 State makes payments to a group health plan (ap-
13 proved under paragraph (2)) which provides cov-
14 erage to the individual as an allowance towards the
15 costs of providing the individual with benefits under
16 the plan.

17 “(2) APPROVED PLANS DESCRIBED.—For pur-
18 poses of paragraph (1), a State shall approve group
19 health plans in accordance with such standards as
20 the State may establish, except that—

21 “(A) the State may not approve a plan for
22 a year unless the plan provides certified stand-
23 ard health coverage described in section
24 1931(j);

1 “(B) at least one of the plans approved by
2 the State shall be a health maintenance organi-
3 zation or other plan under which payments are
4 otherwise made on a capitated basis for provid-
5 ing medical assistance to individuals enrolled in
6 the State plan under this title; and

7 “(C) in the case of an individual who is en-
8 titled to benefits under the State plan under
9 this title as of the first month during which the
10 State health allowance program is in effect, an
11 approved plan may not require the individual to
12 contribute a greater amount of cost-sharing
13 than the individual would have been required to
14 contribute under the State plan (except as may
15 be imposed on an individual described in sub-
16 paragraph (B) or subparagraph (C) of sub-
17 section (d)(1)).

18 “(3) WAIVER OF STATEWIDENESS REQUIRE-
19 MENT.—At the request of a State, the Secretary
20 may waive for a period not to exceed 3 years (sub-
21 ject to one 3-year extension) the requirement under
22 paragraph (1) that the State health allowance pro-
23 gram be in effect in all political subdivisions of the
24 State.

1 “(d) ELIGIBILITY OF INDIVIDUALS TO PARTICIPATE
2 IN ALLOWANCE PROGRAM.—

3 “(1) AUTOMATIC ELIGIBILITY OF MEDICAID
4 CATEGORICALLY ELIGIBLE INDIVIDUALS.—Subject
5 to subsection (e), any individual to whom the State
6 makes medical assistance available under the State
7 plan under this title pursuant to clause (i) of section
8 1902(a)(10)(A) shall be eligible to participate in the
9 State health allowance program.

10 “(2) MANDATORY ELIGIBILITY OF PREGNANT
11 WOMEN WITH INCOME UNDER 150 PERCENT OF THE
12 POVERTY LEVEL.—

13 “(A) IN GENERAL.—Subject to subsection
14 (e) and subparagraph (B), an individual law-
15 fully residing in the State shall be eligible to
16 participate in the program if the individual is a
17 pregnant woman and the income of the individ-
18 ual’s family is equal to or less than 150 percent
19 of the official poverty line (as defined by the
20 Office of Management and Budget, and revised
21 annually in accordance with section 673(2) of
22 the Omnibus Budget Reconciliation Act of
23 1991) applicable to a family of the size in-
24 volved.

1 “(B) EXCEPTION.—If the application of
2 subparagraph (A) would result in—

3 “(i) the total State expenditures for a
4 quarter under this title (including expendi-
5 tures attributable to this section and sec-
6 tion 1923), exceeding

7 “(ii) the total State expenditures that
8 the Secretary estimates would have been
9 made under this title for the quarter if the
10 State did not have a program under this
11 section,

12 then there shall be substituted for 150 percent
13 in subparagraph (A) such percent as would re-
14 sult in the amount described in clause (i) equal-
15 ing the amount described in clause (ii).

16 “(3) OPTIONAL ELIGIBILITY OF OTHER INDI-
17 VIDUALS WITH INCOME UP TO 150 PERCENT OF POV-
18 ERTY LEVEL.—

19 “(A) IN GENERAL.—Subject to subsection
20 (e), a State operating a State health allowance
21 program under this section may make an indi-
22 vidual lawfully residing in the State who is not
23 described in paragraph (2) eligible to partici-
24 pate in the program if the income of the indi-

1 vidual's family is not greater than 150 percent
2 of such official poverty line.

3 “(B) CONTRIBUTION MAY BE REQUIRED.—

4 In the case of an individual who is participating
5 in the program under this paragraph and whose
6 family income is greater than 100 percent of
7 the official poverty line, the program may re-
8 quire such an individual to contribute all (or a
9 portion) of the premiums for such a group
10 health plan if the amount of such contribution
11 is determined in accordance with a sliding scale
12 based on the individual's family income.

13 “(e) EXCLUSION AND USE OF RESOURCE STAND-
14 ARD.—

15 “(1) EXCLUSION OF ELDERLY MEDICARE-ELIGI-
16 BLE INDIVIDUALS.—No individual shall be eligible to
17 participate in the program if the individual is enti-
18 tled to benefits under title XVIII pursuant to section
19 226.

20 “(2) USE OF RESOURCE STANDARD.—A State
21 may require an individual to meet a resource stand-
22 ard as a condition of eligibility to participate in the
23 program only if the Secretary approves the State's
24 use of such a standard.

1 “(f) CONSTRUCTION.—No provision of any Federal
2 law shall prevent a State from enrolling any employee or
3 other individual in accordance with this section. The pre-
4 vious sentence shall not be construed as permitting a State
5 to require the employer of an individual participating in
6 the program to contribute toward the individual’s pre-
7 mium required for such participation.

8 “(g) EVALUATIONS AND REPORTS.—

9 “(1) EVALUATIONS.—Not later than 3 years
10 after the date of the enactment of this section (and
11 at such subsequent intervals as the Secretary consid-
12 ers appropriate), the Secretary shall evaluate the ef-
13 fectiveness of the State health allowance programs
14 for which Federal financial participation is provided
15 under this section, and the impact of such programs
16 on increasing the number of individuals with health
17 insurance coverage in participating States and in
18 controlling the costs of health care in such States.

19 “(2) REPORTS.—Not later than 3 years after
20 the date of the enactment of this section (and at
21 such subsequent intervals as the Secretary considers
22 appropriate), the Secretary shall submit a report on
23 the program to Congress.”.

1 (b) **EFFECTIVE DATE.**—The amendments made by
 2 this section shall apply to calendar quarters beginning on
 3 or after January 1, 1996.

4 **SEC. 1702. OPTIONAL USE OF PROGRAM TO OFFER COV-**
 5 **ERAGE TO SOME OR ALL STATE RESIDENTS.**

6 Section 1932 of the Social Security Act, as inserted
 7 by section 1701(a)(2), is amended—

8 (1) in subsection (c)(2)(A), in the matter before
 9 clause (i), by inserting “, except as provided in sub-
 10 section (d)(4)(B)(iii),” after “unless”, and

11 (2) by adding at the end of subsection (d) the
 12 following new paragraphs:

13 “(4) **OPTIONAL ENROLLMENT OF OTHER INDIV-**
 14 **VIDUALS.**—

15 “(A) **IN GENERAL.**—Subject to subsection
 16 (e), a State operating a State health allowance
 17 program under this section may make any indi-
 18 vidual (or class of individuals) who is not de-
 19 scribed in paragraph (1), (2), or (3) and who
 20 is not offered coverage under an employer
 21 group health plan eligible to participate in the
 22 program.

23 “(B) **SPECIAL RULES.**—

24 “(i) **CONTRIBUTION MAY BE RE-**
 25 **QUIRED.**—In the case of an individual who

1 is participating in the program under this
2 paragraph, the program may require such
3 an individual to contribute all (or a por-
4 tion) of the premiums and cost-sharing of
5 such a group health plan.

6 “(ii) NO FEDERAL MATCHING PAY-
7 MENTS.—For purposes of payment to
8 States under section 1903(a), no amounts
9 expended by the State under the program
10 during a fiscal year on behalf of an indi-
11 vidual enrolled under subparagraph (A)
12 may be included in the total amount ex-
13 pended during the fiscal year as medical
14 assistance under the State plan.

15 “(5) OFFERING OF COVERAGE THROUGH
16 OTHER PROGRAMS.—Nothing in this section shall be
17 construed as preventing a State which—

18 “(A) does not operate a State health allow-
19 ance program under this section from assuring
20 that individuals in the State who are not of-
21 fered coverage under an employer group health
22 plan are offered coverage under a health plan,
23 or

24 “(B) does operate such a program from as-
25 suring that individuals in the State who are not

1 described in paragraph (1), (2), or (3) and who
 2 are not offered coverage under an employer
 3 group health plan are offered coverage under a
 4 health plan other than through such program.”.

5 **PART 2—MEDICAID PROGRAM FLEXIBILITY**

6 **SEC. 1711. MODIFICATION OF FEDERAL REQUIREMENTS TO** 7 **ALLOW STATES MORE FLEXIBILITY IN CON-** 8 **TRACTING FOR COORDINATED CARE SERV-** 9 **ICES UNDER MEDICAID.**

10 (a) IN GENERAL.—Section 1903(m) of the Social Se-
 11 curity Act (42 U.S.C. 1396b(m)) is amended—

12 (1) by striking all that precedes paragraph (4)
 13 and inserting the following:

14 “(m) COORDINATED CARE.—

15 “(1) PAYMENT CONDITIONED ON COMPLI-
 16 ANCE.—

17 “(A) GENERAL RULE.—No payment shall
 18 be made under this title to a State with respect
 19 to expenditures incurred by it for payment to a
 20 risk contracting entity or primary care case
 21 management entity (as defined in subparagraph
 22 (B)), or with respect to an undertaking de-
 23 scribed in paragraph (6), unless the State and
 24 the entity or undertaking meet the applicable
 25 requirements of this subsection. For purposes

1 of determining whether payment may be made
2 under this section, the Secretary may reject a
3 State's determination of compliance with any
4 provision of this subsection.

5 “(B) GENERAL DEFINITIONS.—For pur-
6 poses of this title—

7 “(i) RISK CONTRACTING ENTITY.—
8 The term ‘risk contracting entity’ means
9 an entity that has a contract with the
10 State agency under which the entity—

11 “(I) provides or arranges for the
12 provision of health care items or serv-
13 ices to individuals eligible for medical
14 assistance under the State plan under
15 this title, and

16 “(II) is at risk (as defined in
17 clause (iv)) for part or all of the cost
18 of such items or services furnished to
19 such individuals.

20 “(ii) PRIMARY CARE CASE MANAGE-
21 MENT PROGRAM.—The term ‘primary care
22 case management program’ means a State
23 program under which individuals eligible
24 for medical assistance under the State plan
25 under this title are enrolled with primary

1 care case management entities, and are en-
2 titled to receive specified health care items
3 and services covered under such plan only
4 as arranged for and approved by such enti-
5 ties.

6 “(iii) AT RISK.—An entity is ‘at risk’,
7 for purposes of this subparagraph, if it has
8 a contract with the State agency under
9 which it is paid a fixed amount for provid-
10 ing or arranging for the provision of speci-
11 fied health care items or services to an in-
12 dividual eligible for medical assistance and
13 enrolled with the entity, regardless of
14 whether such items or services are fur-
15 nished to such individual, and is liable for
16 all or part of the cost of furnishing such
17 items or services, regardless of whether or
18 the extent to which such cost exceeds such
19 fixed payment.

20 “(iv) PRIMARY CARE CASE MANAGE-
21 MENT ENTITY.—The term ‘primary care
22 case management entity’ means a health
23 care provider (whether an individual or an
24 entity) that, under a State primary care
25 case management program meeting the re-

quirements of paragraph (7), has a contract with the State agency under which the entity arranges for or authorizes the provision of health care items and services to individuals eligible for medical assistance under the State plan under this title, but is not at risk (as defined in clause (iv)) for the cost of such items or services provided to such individuals.

“(2) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

“(A) FEDERAL OR STATE QUALIFICATION.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if it either—

“(i) is a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as determined by the Secretary pursuant to section 1312 of that Act, or

“(ii) is an entity which the State agency has determined—

“(I) affords, to individuals eligible for medical assistance under the State plan and enrolled with the en-

1 tity, access to health care items and
2 services furnished by the entity, with-
3 in the area served by the entity, at
4 least equivalent to the access such in-
5 dividuals would have to such health
6 care items and services in such area if
7 not enrolled with the entity, and

8 “(II) has made adequate provi-
9 sion against the risk of insolvency,
10 and assures that individuals eligible
11 for medical assistance under this title
12 are not held liable for the entity’s
13 debts in case of the entity’s insol-
14 vency.

15 “(B) INTERNAL QUALITY ASSURANCE.—

16 Subject to paragraph (3), a risk contracting en-
17 tity meets the requirements of this subsection
18 only if it has in effect an internal quality assur-
19 ance program that meets the requirements of
20 paragraph (9).

21 “(C) CONTRACT WITH STATE AGENCY.—

22 Subject to paragraph (3), a risk contracting en-
23 tity meets the requirements of this subsection
24 only if the entity has a written contract with
25 the State agency that provides—

1 “(i) that the entity will comply with
2 all applicable provisions of this subsection;

3 “(ii) for a payment methodology based
4 on experience rating or another actuarially
5 sound methodology approved by the Sec-
6 retary, which guarantees (as demonstrated
7 by such models or formulas as the Sec-
8 retary may approve) that payments to the
9 entity under the contract shall not exceed
10 100 percent of expenditures that would
11 have been made by the State agency in the
12 absence of the contract;

13 “(iii) that the Secretary and the State
14 (or any person or organization designated
15 by either) shall have the right to audit and
16 inspect any books and records of the entity
17 (and of any subcontractor) that pertain—

18 “(I) to the ability of the entity to
19 bear the risk of potential financial
20 losses, or

21 “(II) to services performed or de-
22 terminations of amounts payable
23 under the contract;

24 “(iv) that in the entity’s enrollment,
25 reenrollment, or disenrollment of individ-

1 uals eligible for medical assistance under
2 this title and eligible to enroll, reenroll, or
3 disenroll with the entity pursuant to the
4 contract, the entity will not discriminate
5 among such individuals on the basis of
6 their health status or requirements for
7 health care services;

8 “(v)(I) that individuals eligible for
9 medical assistance under the State plan
10 who have enrolled with the entity are per-
11 mitted to terminate such enrollment with-
12 out cause as of the beginning of the first
13 calendar month following a full calendar
14 month after the request is made for such
15 termination (or at such times as required
16 pursuant to paragraph (8)), and

17 “(II) for notification of each such in-
18 dividual, at the time of the individual’s en-
19 rollment, of the right to terminate enroll-
20 ment;

21 “(vi) for reimbursement, either by the
22 entity or by the State agency, for medically
23 necessary services provided—

1 “(I) to an individual eligible for
2 medical assistance under the State
3 plan and enrolled with the entity, and

4 “(II) other than through the en-
5 tity because the services were imme-
6 diately required due to an unforeseen
7 illness, injury, or condition;

8 “(vii) for disclosure of information in
9 accordance with paragraph (4);

10 “(viii) in the case of an entity that
11 has entered into a contract with a Feder-
12 ally-qualified health center for the provi-
13 sion of services of such center—

14 “(I) that rates of prepayment
15 from the State are adjusted to reflect
16 fully the rates of payment specified in
17 section 1902(a)(13)(E), and

18 “(II) that, at the election of such
19 center, payments made by the entity
20 to such center for services described
21 in section 1905(a)(2)(C) are made at
22 the rates of payment specified in sec-
23 tion 1902(a)(13)(E);

1 “(ix) that any physician incentive plan
2 that the entity operates meets the require-
3 ments of section 1876(i)(8);

4 “(x) for maintenance of sufficient pa-
5 tient encounter data to identify the physi-
6 cian who delivers services to patients; and

7 “(xi) that the entity complies with the
8 requirement of section 1902(w) with re-
9 spect to each enrollee.

10 “(3) EXCEPTIONS TO REQUIREMENTS FOR RISK
11 CONTRACTING ENTITIES.—The requirements of
12 paragraph (2) (other than subparagraph (C)(viii))
13 do not apply to an entity that—

14 “(A)(i) received a grant of at least
15 \$100,000 in the fiscal year ending June 30,
16 1976, under section 329(d)(1)(A) or 330(d)(1)
17 of the Public Health Service Act, and for the
18 period beginning July 1, 1976, and ending on
19 the expiration of the period for which payments
20 are to be made under this title, has been the re-
21 cipient of a grant under either such section;
22 and

23 “(ii) provides to its enrollees, on a prepaid
24 capitation or other risk basis, all of the services
25 described in paragraphs (1), (2), (3), (4)(C),

1 and (5) of section 1905(a) and, to the extent
2 required by section 1902(a)(10)(D) to be pro-
3 vided under the State plan, the services de-
4 scribed in section 1905(a)(7);

5 “(B) is a nonprofit primary health care en-
6 tity located in a rural area (as defined by the
7 Appalachian Regional Commission)—

8 “(i) which received in the fiscal year
9 ending June 30, 1976, at least \$100,000
10 (by grant, subgrant, or subcontract) under
11 the Appalachian Regional Development Act
12 of 1965), and

13 “(ii) for the period beginning July 1,
14 1976, and ending on the expiration of the
15 period for which payments are to be made
16 under this title either has been the recipi-
17 ent of a grant, subgrant, or subcontract
18 under such Act or has provided services
19 under a contract (initially entered into dur-
20 ing a year in which the entity was the re-
21 cipient of such a grant, subgrant, or sub-
22 contract) with a State agency under this
23 title on a prepaid capitation or other risk
24 basis; or

“(C) which has contracted with the State agency for the provision of services (but not including inpatient hospital services) to persons eligible for medical assistance under this title on a prepaid risk basis prior to 1970.”; and
(2) by adding after paragraph (6) the following new paragraphs:

“(7) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT.—A State that elects in its State plan under this title to implement a primary care case management program under this subsection shall include in the plan methods for the selection and monitoring of participating primary care case management entities to ensure that—

“(A) the numbers, geographic locations, hours of operation, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance reasonable access to and choice among such entities;

“(B) such entities and their professional personnel are qualified to provide health care case management services, through methods including ongoing monitoring of compliance with applicable requirements for licensing of health

1 care providers, providing training and certifi-
2 cation of primary care case managers, and pro-
3 viding information and technical assistance; and

4 “(C) such entities are making timely and
5 appropriate decisions with respect to enrollees’
6 need for health care items and services, and are
7 giving timely approval and referral to providers
8 of adequate quality where such items and serv-
9 ices are determined to be medically necessary.

10 “(8) STATE OPTIONS WITH RESPECT TO EN-
11 ROLLMENT AND DISENROLLMENT.—

12 “(A) MANDATORY ENROLLMENT OP-
13 TION.—A State plan may require an individual
14 eligible for medical assistance under the State
15 plan (other than a medicare qualified bene-
16 ficiary) to enroll with a risk contracting entity
17 or primary care case management entity, with-
18 out regard to the requirement of section
19 1902(a)(1) (concerning statewideness), the re-
20 quirements of section 1902(a)(10)(B) (concern-
21 ing comparability of benefits), or the require-
22 ments of section 1902(a)(23) (concerning free-
23 dom of choice of provider), if the individual is
24 permitted a choice—

1 “(i) between or among two or more
2 risk contracting entities,

3 “(ii) between a risk contracting entity
4 and a primary care case management en-
5 tity, or

6 “(iii) between or among two or more
7 primary care case management entities.

8 “(B)(i) RESTRICTIONS ON DISENROLL-
9 MENT WITHOUT CAUSE.—A State plan may re-
10 strict the period in which individuals enrolled
11 with a qualifying risk contracting entity (as de-
12 fined in clause (ii)) may terminate such enroll-
13 ment without cause to the first month of each
14 period of enrollment (as defined in clause (iii)),
15 but only if the State provides notification, at
16 least once during each such enrollment period,
17 to individuals enrolled with such entity of the
18 right to terminate such enrollment and the re-
19 striction on the exercise of this right. Such re-
20 striction shall not apply to requests for termi-
21 nation of enrollment for cause.

22 “(ii) For purposes of this subparagraph,
23 the term ‘qualifying risk contracting entity’
24 means a risk contracting entity that is—

1 “(I) a qualified health maintenance
2 organization as defined in section 1310(d)
3 of the Public Health Service Act;

4 “(II) an eligible organization with a
5 contract under section 1876;

6 “(III) an entity that is receiving (and
7 has received during the previous 2 years)
8 a grant of at least \$100,000 under section
9 329(d)(1)(A) or 330(d)(1) of the Public
10 Health Service Act;

11 “(IV) an entity that is receiving (and
12 has received during the previous 2 years)
13 at least \$100,000 (by grant, subgrant, or
14 subcontract) under the Appalachian Re-
15 gional Development Act of 1965;

16 “(V) a program pursuant to an under-
17 taking described in paragraph (6) in which
18 at least 25 percent of the membership en-
19 rolled on a prepaid basis are individuals
20 who (I) are not insured for benefits under
21 part B of title XVIII or eligible for medical
22 assistance under this title, and (II) (in the
23 case of such individuals whose prepay-
24 ments are made in whole or in part by any
25 government entity) had the opportunity at

1 the time of enrollment in the program to
2 elect other coverage of health care costs
3 that would have been paid in whole or in
4 part by any governmental entity; or

5 “(VI) an entity that, on the date of
6 enactment of this provision, had a contract
7 with the State agency under a waiver
8 under section 1115 or 1915(b) and was
9 not subject to a requirement under this
10 subsection to permit disenrollment without
11 cause.

12 “(iii) For purposes of this subparagraph,
13 the term ‘period of enrollment’ means—

14 “(I) a period not to exceed 6 months
15 in duration, or

16 “(II) a period not to exceed one year
17 in duration, in the case of a State that, on
18 the effective date of this subparagraph,
19 had in effect a waiver under section 1115
20 of requirements under this title under
21 which the State could establish a 1-year
22 minimum period of enrollment with risk
23 contracting entities.

“(C) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

“(i) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this subsection,

“(ii) in the next month (or next 2 months) is not eligible for such medical assistance, but

“(iii) in the succeeding month is again eligible for such benefits,

the State plan may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.

“(9) REQUIREMENTS FOR INTERNAL QUALITY ASSURANCE PROGRAMS.—The requirements for an internal quality assurance program of a risk contracting entity are that program is written and the program—

“(A) specifies a systematic process including ongoing monitoring, corrective action, and other appropriate activities to achieve specified and measurable goals and objectives for quality

1 of care, and including annual evaluation of the
2 program;

3 “(B) identifies the organizational units re-
4 sponsible for performing specific quality assur-
5 ance functions, and ensure that they are ac-
6 countable to the governing body of the entity
7 and that they have adequate supervision, staff,
8 and other necessary resources to perform these
9 functions effectively;

10 “(C) if any quality assistance functions are
11 delegated to other entities, ensures that the risk
12 contracting entity remains accountable for all
13 quality assurance functions, and has mecha-
14 nisms to ensure that all quality assurance ac-
15 tivities are carried out;

16 “(D) includes methods to ensure that phy-
17 sicians and other health care professionals
18 under contract with the entity are qualified to
19 perform the services they provide, and that
20 these qualifications are ensured through appro-
21 priate credentialing and recredentialing proce-
22 dures;

23 “(E) includes policies addressing enrollee
24 rights and responsibilities, including grievance
25 mechanisms and mechanisms to inform enroll-

ees about access to and use of services provided
by the entity;

“(F) provides for continuous monitoring of
the delivery of health care, including—

“(i) identification of clinical areas to
be monitored,

“(ii) use of quality indicators and
standards for assessing care delivered, in-
cluding availability and accessibility of
care,

“(iii) monitoring, through use of epi-
demiological data or chart review, the care
of individuals, as appropriate, and patterns
of care overall, and

“(iv) implementation of corrective ac-
tions; and

“(G) meets any other requirements pre-
scribed by the Secretary after consultation with
States.

“(10) INDEPENDENT REVIEW AND QUALITY AS-
SURANCE.—

“(A) STATE GRIEVANCE PROCEDURE.—A
State contracting with a risk contracting entity
or primary care case management entity under
this subsection shall provide for a grievance

1 procedure for enrollees of such entity with at
2 least the following elements:

3 “(i) A toll-free telephone number for
4 enrollee questions and grievances.

5 “(ii) A State-operated enrollee griev-
6 ance procedure.

7 “(iii) Periodic notification of enrollees
8 of their rights with respect to such entity
9 or program.

10 “(iv) Periodic sample reviews of griev-
11 ances registered with such entity or pro-
12 gram or with the State.

13 “(v) Periodic survey and analysis of
14 enrollee satisfaction with such entity or
15 program.

16 “(B) STATE MONITORING OF RISK CON-
17 TRACTING ENTITIES’ QUALITY ASSURANCE PRO-
18 GRAMS.—A State contracting with a risk con-
19 tracting entity under this subsection shall peri-
20 odically review such entity’s quality assurance
21 program to ensure that it meets the require-
22 ments of paragraph (9).

23 “(C) EXTERNAL INDEPENDENT REVIEW
24 OF INTERNAL QUALITY ASSURANCE.—A State
25 contracting with a risk contracting entity under

1 this subsection shall provide for annual external
2 independent review (by a utilization control and
3 peer review organization with a contract under
4 section 1153, or another organization unaffili-
5 ated with the State government approved by the
6 Secretary) of such entity's internal quality as-
7 surance activities. Such independent review
8 shall include—

9 “(i) review of the entity's medical
10 care, through sampling of medical records
11 or other appropriate methods, for indica-
12 tions of inappropriate utilization and treat-
13 ment,

14 “(ii) review of enrollee inpatient and
15 ambulatory data, through sampling of
16 medical records or other appropriate meth-
17 ods, to determine quality trends,

18 “(iii) review of the entity's internal
19 quality assurance activities, and

20 “(iv) notification of the entity and the
21 State, and appropriate followup activities,
22 when the review under this subparagraph
23 indicates inappropriate care or treat-
24 ment.”.

1 (b) STATE OPTION TO GUARANTEE MEDICAID ELI-
2 GIBILITY.—Section 1902(e)(2) of such Act (42 U.S.C.
3 1396a(e)(2)) is amended—

4 (A) in subparagraph (A), by striking all
5 that precedes “(but for this paragraph)” and
6 inserting “In the case of an individual who is
7 enrolled—

8 “(i) with a risk contracting entity (as
9 defined in section 1903(m)(1)(B)(i)) re-
10 sponsible for the provision of inpatient hos-
11 pital services and any other service de-
12 scribed in paragraphs (2), (3), (4), (5),
13 and (7) of section 1905(a),

14 “(ii) with any risk contracting entity
15 (as so defined) in a State that, on the ef-
16 fective date of this provision, had in effect
17 a waiver under section 1115 of require-
18 ments under this title under which the
19 State could extend eligibility for medical
20 assistance for enrollees of such entity, or

21 “(iii) with an eligible organization
22 with a contract under section 1876 and
23 who would”, and

24 (B) in subparagraph (B), by striking “or-
25 ganization or” each place it appears.

(c) CONFORMING AMENDMENTS.—

(1) Section 1128(b)(6)(C)(i) of such Act (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking “health maintenance organization” and inserting “risk contracting entity”.

(2) Section 1902(a)(25)(A) of such Act (42 U.S.C. 1396a(a)(25)(A)), as amended by section 13622(a)(1) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking “health maintenance organizations” and inserting “risk contracting entities”.

(3) Section 1902(a)(25)(H) of such Act (42 U.S.C. 1396a(a)(25)(H)), as added by section 13622(b)(3) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking “health maintenance organization” and inserting “risk contracting entity”.

(4) Section 1902(a)(30)(C) of such Act (42 U.S.C. 1396a(a)(30)(C)) is amended by striking all that precedes “with the results” and inserting “provide for independent review and quality assurance of entities with contracts under section 1903(m), in accordance with paragraph (10) of such section,”.

(5) Section 1902(a)(57) of such Act (42 U.S.C. 1396a(a)(57)) is amended by striking “or health

1 maintenance organization” and inserting “or risk
2 contracting entity”.

3 (6) Section 1902(a) of such Act (42 U.S.C.
4 1396a(a)), as amended by sections 13623(a),
5 13625(a), and 13631(a) of the Omnibus Budget
6 Reconciliation Act of 1993, is amended—

7 (A) by striking “and” at the end of para-
8 graph (61);

9 (B) by striking the period at the end of
10 paragraph (62) and inserting “; and”; and

11 (C) by adding at the end the following new
12 paragraph:

13 “(63) at State option, provide for a primary
14 care case management program in accordance with
15 section 1903(m)(7).”.

16 (7) Section 1902(p)(2) of such Act (42 U.S.C.
17 1396a(p)(2)) is amended by striking “health mainte-
18 nance organization” and inserting “risk contracting
19 entity”.

20 (8) Section 1902(w) of such Act (42 U.S.C.
21 1396a(w)) is amended—

22 (A) in paragraph (1), by striking “section
23 1903(m)(1)(A)” and inserting “section
24 1903(m)(2)(C)(xi)”, and

(B) in paragraph (2)(E), by striking “health maintenance organization” and “the organization” and inserting “risk contracting entity” and “the entity”, respectively.

(9) Section 1903(k) of such Act (42 U.S.C. 1396b(k)) is amended by striking “health maintenance organization” and inserting “risk contracting entity”.

(10) Section 1903(m)(4)(A) of such Act (42 U.S.C. 1396b(m)(4)(A)) is amended—

(A) in the first sentence, by striking “Each health maintenance organization” and inserting “Each risk contracting entity”,

(B) in the first sentence, by striking “the organization” each place it appears and inserting “the entity”, and

(C) in the second sentence, by striking “an organization” and “the organization” and inserting “a risk contracting entity” and “the risk contracting entity”, respectively.

(11) Section 1903(m)(4)(B) of such Act (42 U.S.C. 1396b(m)(4)(B)) is amended by striking “organization” and inserting “risk contracting entity”.

(12) Section 1903(m)(5) of such Act (42 U.S.C. 1396b(m)(5)) is amended in paragraphs

1 (A)(iii) and (B)(ii) by striking “organization” and
2 inserting “entity”.

3 (13) Section 1903(o) (42 U.S.C. 1396b(o)), as
4 amended by section 13622(a)(2) of the Omnibus
5 Budget Reconciliation Act of 1993, is amended by
6 striking “health maintenance organization” and in-
7 serting “risk contracting entity”.

8 (14) Section 1903(w)(7)(A)(viii) of such Act
9 (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by
10 striking “health maintenance organizations (and
11 other organizations with contracts under section
12 1903(m))” and inserting “risk contracting entities
13 with contracts under section 1903(m)”.

14 (15) Section 1905(a) of such Act (42 U.S.C.
15 1396d(a)) is amended, in the matter preceding
16 clause (i), by inserting “(which may be on a prepaid
17 capitation or other risk basis)” after “payment” the
18 first place it appears.

19 (16) Section 1908(b) of such Act, as added by
20 section 13623(b) of the Omnibus Budget Reconcili-
21 ation Act of 1993, is amended by striking “health
22 maintenance organization” and inserting “risk con-
23 tracting entity”.

24 (17) Section 1916(b)(2)(D) of such Act (42
25 U.S.C. 1396o(b)(2)(D)) is amended by striking

1 “health maintenance organization” and inserting
2 “risk contracting entity”.

3 (18) Section 1925(b)(4)(D)(iv) of such Act (42
4 U.S.C. 1396r-6(b)(4)(D)(iv)) is amended—

5 (A) in the heading, by striking “HMO” and
6 inserting “RISK CONTRACTING ENTITY”,

7 (B) by striking “health maintenance orga-
8 nization” and inserting “risk contracting en-
9 tity” each place it appears, and

10 (C) by striking “section 1903(m)(1)(A)”
11 and inserting “section 1903(m)(1)(B)(i)”.

12 (19) Paragraphs (1) and (2) of section 1926(a)
13 of such Act (42 U.S.C. 1396r-7(a)) are each amend-
14 ed by striking “health maintenance organizations”
15 and inserting “risk contracting entities”.

16 (20) Section 1927 of such Act (42 U.S.C.
17 1396s) is amended—

18 (A) in subsection (c)(1)(C)(i), as amended
19 by section 13602(a)(1) of the Omnibus Budget
20 Reconciliation Act of 1993, by striking “health
21 maintenance organization” and inserting “risk
22 contracting entity” , and

23 (B) in subsection (j)(1), by striking “***
24 Health Maintenance Organizations, including

1 those organizations” and inserting “risk con-
2 tracting entities”.

3 (d) **EFFECTIVE DATE.**—The amendments made by
4 this section shall become effective with respect to calendar
5 quarters beginning on or after January 1, 1995.

6 **SEC. 1712. PERIOD OF CERTAIN WAIVERS.**

7 (a) **IN GENERAL.**—Section 1915(h) of the Social Se-
8 curity Act (42 U.S.C. 1396n(h)) is amended by striking
9 “No waiver” and all that follows through “unless the Sec-
10 retary” and inserting “A waiver under this section (other
11 than under subsection (c), (d), or (e)) shall be for an ini-
12 tial term of 3 years and, upon the request of a State, shall
13 be extended for additional 5 year periods unless the Sec-
14 retary”.

15 (b) **EFFECTIVE DATE.**—The amendment made by
16 subsection (a) shall apply to waivers pursuant to applica-
17 tions which are approved, and with respect to continu-
18 ations of waivers for which requests are made, later than
19 30 days after the date of the enactment of this Act.

20 **SEC. 1713. ELIMINATION OF DUPLICATIVE PEDIATRIC IM-**
21 **MUNIZATION PROGRAM.**

22 Effective as if included in the enactment of the 13621
23 of the Omnibus Budget Reconciliation Act of 1993, title
24 XIX of the Social Security Act is amended as follows:

25 (1) Section 1902(a) is amended—

1 (A) by adding “and” at the end of para-
2 graph (60),

3 (B) by striking “; and” at the end of para-
4 graph (61) and inserting a period, and

5 (C) by striking paragraph (62).

6 (2) Section 1928 is repealed.

7 (3) Section 1903(i) is amended—

8 (A) by inserting “or” at the end of para-
9 graph (12),

10 (B) by striking the semicolon at the end of
11 paragraph (13) and inserting a period, and

12 (C) by striking paragraphs (14) and (15).

13 (4) Section 1902(a)(32) is amended—

14 (A) by adding “and” at the end of sub-
15 paragraph (B),

16 (B) by striking “; and” at the end of sub-
17 paragraph (C) and inserting a period, and

18 (C) by striking subparagraph (D).

19 (5) Section 1902(a) is amended—

20 (A) in paragraph (11)(B)—

21 (ii) by inserting “and” before “(ii)”,

22 and

23 (iii) by striking “to the individual
24 under section 1903, and (iii) providing for
25 coordination of information and education

1 on pediatric vaccinations and delivery of
2 immunization services” and inserting “to
3 him under section 1903”;

4 (B) in paragraph (11)(C), by striking “,
5 including the provision of information and edu-
6 cation on pediatric vaccinations and the delivery
7 of immunization services,” and

8 (C) in paragraph (43)(A), by striking “and
9 the need for age-appropriate immunizations
10 against vaccine-preventable diseases”.

11 (6) Section 1905(r)(1) is amended—

12 (A) in subparagraph (A)(i), by striking
13 “and, with respect to immunizations under sub-
14 paragraph (B)(iii), in accordance with the
15 schedule referred to in section 1928(c)(2)(B)(i)
16 for pediatric vaccines”; and

17 (B) in subparagraph (B)(iii), by striking
18 “(according to the schedule referred to in sec-
19 tion 1928(c)(2)(B)(i) for pediatric vaccines)”.

1 **PART 3—MEDICAID DISPROPORTIONATE SHARE**

2 **ADJUSTMENT**

3 **SEC. 1721. 25 PERCENT REDUCTION IN AMOUNT OF PAY-**

4 **MENT ADJUSTMENTS FOR DISPROPORTION-**

5 **ATE SHARE HOSPITALS.**

6 (a) IN GENERAL.—Section 1923 of the Social Secu-
7 rity Act (42 U.S.C. 1396r-4) is amended by adding at
8 the end the following new subsection:

9 “(h) REDUCTION IN FEDERAL FINANCIAL PARTICI-
10 PATION FOR DISPROPORTIONATE SHARE ADJUST-
11 MENTS.—Notwithstanding any other provision of this sec-
12 tion, the amount of payments under section 1903(a) with
13 respect to any payment adjustment made under this sec-
14 tion for hospitals in a State for quarters in a fiscal year
15 shall not exceed 75 percent of the amount otherwise deter-
16 mined under subsection (f).”.

17 (b) CONFORMING AMENDMENT.—Section 1923(c) of
18 such Act (42 U.S.C. 1396r-4(c)) is amended in the matter
19 preceding paragraph (1) by striking “(f) and (g)” and in-
20 serting “(f), (g), and (h)”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 subsections (a) and (b) shall apply to quarters in fiscal
23 years beginning on or after October 1, 1996.

1 Subtitle I—Remedies and Enforce-
2 ment With Respect to Group
3 Health Plans

4 SEC. 1801. CLAIMS PROCEDURE FOR GROUP HEALTH
5 PLANS.

6 (a) IN GENERAL.—Section 503 of the Employee Re-
7 tirement Income Security Act of 1974 (29 U.S.C. 1133)
8 is amended—

9 (1) by inserting “(a) IN GENERAL.—” after
10 “SEC. 503.”; and

11 (2) by adding at the end the following new sub-
12 section:

13 “(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

14 “(1) IN GENERAL.—In addition to meeting the
15 requirements of subsection (a), every group health
16 plan shall afford a reasonable opportunity to any
17 participant or beneficiary, whose request for a
18 preauthorization, an emergency preauthorization, a
19 utilization review determination, or an emergency
20 utilization review determination has been denied, for
21 a full and fair review by the appropriate fiduciary of
22 the decision denying the request

23 “(2) TIME LIMITS FOR DECIDING CLAIMS.—

24 “(A) INITIAL DECISIONS.—A group health
25 plan shall issue an initial approval or denial of

1 any claim for medical, surgical, or hospital ben-
2 efits not later than 30 days after its filing com-
3 pletion date. Failure to approve or deny such a
4 claim within such 30-day period shall be treated
5 as a denial of the claim.

6 “(B) REVIEWS OF INITIAL DECISIONS.—
7 Every review by a fiduciary required under
8 paragraph (1) of an initial denial under sub-
9 paragraph (A) shall be completed not later than
10 30 days after the review filing date. Failure to
11 issue a decision affirming, reversing, or modify-
12 ing the initial denial shall be treated as a final
13 decision denying the claim.

14 “(3) TIME LIMIT FOR DECIDING REQUESTS FOR
15 PREAUTHORIZATION.—

16 “(A) GENERAL RULE.—Except as provided
17 in subparagraph (B)—

18 “(i) INITIAL DECISIONS.—If a request
19 for preauthorization is required under the
20 terms of a group health plan, the plan
21 shall approve or deny any such request not
22 later than 30 days after its filing comple-
23 tion date. Failure to approve or deny such
24 a request within such 30-day period shall
25 be treated as a denial of the request.

1 “(ii) REVIEWS OF INITIAL DECI-
2 SIONS.—Every review by a fiduciary re-
3 quired under paragraph (1) of an initial
4 denial under clause (i) shall be completed
5 not later than 30 days after the review fil-
6 ing date. Failure to issue a decision affirm-
7 ing, reversing, or modifying the initial de-
8 nial within such 30-day period shall be
9 treated as a final decision denying the re-
10 quest.

11 “(B) REQUESTS FOR EMERGENCY
12 PREAUTHORIZATION.—

13 “(i) INITIAL DECISIONS.—In any case
14 in which a request for preauthorization re-
15 quired under the terms of a group health
16 plan is a request for emergency
17 preauthorization, the plan shall approve or
18 deny any such request not later than 10
19 days after its filing completion date (24
20 hours after such date in cases involving
21 emergency medical care). Failure to ap-
22 prove or deny such a request within such
23 10-day period (or 24-hour period) shall be
24 treated as a denial of the request.

1 “(ii) REVIEWS OF INITIAL DECI-
2 SIONS.—Every review by a fiduciary re-
3 quired under paragraph (1) of an initial
4 denial under clause (i) shall be completed
5 not later than 10 days after the review fil-
6 ing date (24 hours after such date in cases
7 involving emergency medical care). Failure
8 to issue a decision affirming, reversing, or
9 modifying the initial denial within such 10-
10 day period (or 24-hour period) shall be
11 treated as a final decision denying the re-
12 quest.

13 “(4) TIME LIMIT FOR DECIDING REQUESTS FOR
14 UTILIZATION REVIEW DETERMINATIONS.—

15 “(A) GENERAL RULE.—Except as provided
16 in subparagraph (B)—

17 “(i) INITIAL DECISIONS.—If a request
18 for a utilization review determination is re-
19 quired under the terms of a group health
20 plan, the plan shall approve or deny any
21 such request not later than 30 days after
22 its filing completion date. Failure to ap-
23 prove or deny such a request within such
24 30-day period shall be treated as a denial
25 of the request.

1 “(ii) REVIEWS OF INITIAL DECI-
2 SIONS.—Every review by a fiduciary re-
3 quired under paragraph (1) of an initial
4 denial under clause (i) shall be completed
5 not later than 30 days after the review fil-
6 ing date. Failure to issue a decision affirm-
7 ing, reversing, or modifying the initial de-
8 nial within such 30-day period shall be
9 treated as a final decision denying the re-
10 quest.

11 “(B) REQUESTS FOR EMERGENCY UTILIZA-
12 TION REVIEW DETERMINATIONS.—

13 “(i) INITIAL DECISIONS.—In any case
14 in which a request for a utilization review
15 determination required under the terms of
16 a group health plan is a request for an
17 emergency utilization review determination,
18 the plan shall approve or deny any such re-
19 quest not later than 10 days after its filing
20 completion date (24 hours after such date
21 in cases involving emergency medical care).
22 Failure to approve or deny such a request
23 within such 10-day period (or 24-hour pe-
24 riod) shall be treated as a denial of the re-
25 quest.

“(ii) **REVIEWS OF INITIAL DECISIONS.**—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 10 days after the review filing date (24 hours after such date in cases involving emergency medical care). Failure to issue a decision affirming, reversing, or modifying the initial denial within such 10-day period (or 24-hour period) shall be treated as a final decision denying the request.

“(5) **DEFINITIONS.**—For purposes of this subsection—

“(A) **CLAIM FOR MEDICAL, SURGICAL, OR HOSPITAL BENEFITS.**—The term ‘claim for medical, surgical, or hospital benefits’ means a request for payment by a group health plan of such benefits made by or on behalf of a participant or beneficiary after the expense for medical, surgical, or hospital care has been incurred.

“(B) **UTILIZATION REVIEW DETERMINATION.**—The term ‘utilization review determination’ means a determination under a group health plan solely that proposed medical, sur-

gical, or hospital care is medically necessary (as defined in section 1131(7) of the Health Security Act). Unless otherwise expressly provided under the terms of the plan, any such determination shall not by itself constitute a guarantee that benefits under the plan will be provided.

“(C) PREAUTHORIZATION.—The term ‘preauthorization’ means a determination under a group health plan that proposed medical, surgical, or hospital care meets the plan’s terms and conditions of coverage. Such a determination shall constitute a guarantee that benefits under the plan will be provided.

“(D) REQUEST FOR PREAUTHORIZATION.—The term ‘request for preauthorization’ means a request for preauthorization by a group health plan of medical, surgical, or hospital benefits made by or on behalf of a participant or beneficiary before the expense for such care has been incurred.

“(E) REQUEST FOR EMERGENCY PREAUTHORIZATION.—The term ‘request for emergency preauthorization’ means a request for preauthorization. by a group health plan in

any case in which the medical, surgical, or hospital benefits for which the expense is to be incurred constitutes urgent medical care or emergency medical care.

“(F) REQUEST FOR UTILIZATION REVIEW DETERMINATION.—The term ‘request for a utilization review determination’ means a request by or on behalf of a participant or beneficiary, made before an expense for medical, hospital, or surgical care has been incurred, for a utilization review determination by a plan.

“(G) REQUEST FOR EMERGENCY UTILIZATION REVIEW DETERMINATION.—The term ‘request for an emergency utilization review determination’ means a request for a utilization review determination in any case in which the medical, hospital, or surgical care to be incurred constitutes urgent medical care or emergency medical care.

“(H) URGENT MEDICAL CARE.—The term ‘urgent medical care’ means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in writing that failure to provide the participant or

beneficiary with such care within 45 days will result in either—

“(i) the death of the participant or beneficiary within 120 days, or

“(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary within 120 days which will significantly increase the reasonable likelihood of death of the participant or beneficiary.

“(I) EMERGENCY MEDICAL CARE.—The term ‘emergency medical care’ means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in writing—

“(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

“(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

1 “(II) serious impairment to bod-
2 ily functions, or

3 “(III) serious dysfunction of any
4 bodily organ or part,

5 or

6 “(ii) that immediate provision of the
7 care is necessary because the participant
8 or beneficiary has made or is at serious
9 risk of making an attempt to harm himself
10 or herself or another individual.

11 “(J) FILING COMPLETION DATE.—The
12 term ‘filing completion date’ means, in connec-
13 tion with a group health plan, the date as of
14 which the plan is in receipt of all information
15 reasonably required to make an initial decision
16 to approve or deny a claim for medical, sur-
17 gical, or hospital benefits, a request for
18 preauthorization, a request for emergency
19 preauthorization, a request for a utilization re-
20 view determination or a request for an emer-
21 gency utilization review determination.

22 “(K) REVIEW FILING DATE.—The term
23 ‘review filing date’ means, in connection with a
24 group health plan, the date as of which the ap-
25 propriate fiduciary is in receipt of all informa-

tion reasonably required to make a decision upon a full and fair review of the denial, in whole or in part, of a claim for medical, surgical, or hospital benefits, a request for preauthorization, a request for emergency preauthorization, a request for a utilization review determination or a request for an emergency utilization review determination.

“(L) APPROPRIATE FIDUCIARY.—The term ‘appropriate fiduciary’ means with respect to any determination under a group health plan a person designated by the plan to make such determination. One or more appropriate fiduciaries shall be designated under each group health plan for making determinations under the plan.”.

(b) DEFINITION OF GROUP HEALTH PLAN.—

(1) IN GENERAL.—Section 3 of such Act (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

“(42) The term ‘group health plan’ means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.”.

(2) CONFORMING AMENDMENT.—Section 607 of such Act (29 U.S.C. 1167) is amended by striking paragraph (1).

SEC. 1802. MEDIATION OF GROUP HEALTH PLAN CLAIMS.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by inserting below the heading for part 5 the following:

“Subpart A—In General”;

and

(2) by adding at the end the following new subpart:

“Subpart B—Mediation of Group Health Plan Claims

“SEC. 521. ELIGIBILITY FOR SUBMISSION TO MEDIATION.

“(a) IN GENERAL.—The Secretary shall establish a mediation program under this subpart (hereinafter in this subpart referred to as the ‘mediation program’) for the purpose of facilitating mediation of disputes meeting the requirements specified in subsection (b). At the time notice is provided to any participant or beneficiary of a group health plan’s denial of any claim for benefits pursuant to section 503, the plan shall provide reasonable notice in writing to the participant or beneficiary whose claim for benefits under the plan has been denied of the avail-

1 ability of mediation under this subpart at the election of
2 either the claimant or the plan.

3 “(b) DISPUTE CRITERIA.—A dispute may be submit-
4 ted for mediation under the mediation program only if the
5 following requirements are met with respect to such dis-
6 pute:

7 “(1) PARTIES.—The dispute consists of an as-
8 sertion by a participant, a beneficiary, or the duly
9 authorized representative of a participant or bene-
10 ficiary (or, in the case of an assignment, the as-
11 signee) of one or more claims under a group health
12 plan, and a denial of such claims, or a denial of ap-
13 propriate reimbursement based on such claims, by
14 such plan or an appropriate fiduciary.

15 “(2) NATURE OF CLAIM.—The claim consists of
16 a claim for benefits for medical, surgical, or hospital
17 expenses under a group health plan which consist of
18 benefits described in section 3(1).

19 “(3) SUBMISSION AFTER EXHAUSTION OF
20 PLAN REMEDIES.—The claimant has received a
21 final determination regarding the claim under the
22 plan’s claims procedure under section 503, or has
23 otherwise exhausted all remedies under the plan pro-
24 vided pursuant to section 503.

1 “(4) APPROPRIATE FIDUCIARY.—For purposes
2 of this subpart, the term ‘appropriate fiduciary’ has
3 the meaning provided in section 503(b)(5)(K).

4 **“SEC. 522. FACILITATORS.**

5 “(a) ROSTER.—The Secretary shall maintain a list
6 of individuals with appropriate expertise to serve as
7 facilitators in proceedings under the mediation program.

8 “(b) CRITERIA.—In identifying individuals to serve
9 as facilitators, the Secretary shall consider the following:

10 “(1) the individual’s experience in dispute reso-
11 lution;

12 “(2) the individual’s ability to act impartially;

13 “(3) the individual’s ability to perform evalua-
14 tions quickly and to present them in nontechnical
15 terms; and

16 “(4) the individual’s experience in employee
17 medical, hospital, and surgical benefits.

18 “(c) APPOINTMENT OF FACILITATOR.—Within 15
19 days after either party files with the Secretary an election
20 of mediation with respect to a dispute, the Secretary shall
21 propose a facilitator, selected under a random selection
22 procedure prescribed in regulations, and notify the parties
23 of such selection. Within 10 days after receipt of the noti-
24 fication of the selection of a facilitator, either party may
25 reject the proposed facilitator. If neither party objects to

1 the Secretary's proposed facilitator within such 10-day pe-
2 riod, the appointment shall become final. If either party
3 objects to the Secretary's proposed facilitator, the proce-
4 dure set forth in the preceding provisions of this sub-
5 section shall be repeated. Each party is limited to 1 objec-
6 tion to the Secretary's proposed facilitator for each medi-
7 ation.

8 **"SEC. 523. ROLE OF ATTORNEYS.**

9 "Parties may represent themselves or be represented
10 by attorneys throughout the mediation process.

11 **"SEC. 524. INITIATION OF MEDIATION.**

12 "(a) CLAIMANT INITIATION.—A claimant may initi-
13 ate mediation of a dispute under this subpart only if no
14 action has been commenced by the claimant under section
15 502 with respect to any claim involved. To initiate medi-
16 ation, a claimant shall file an election for mediation with
17 the Secretary (and shall file a copy of the election with
18 the plan or the appropriate fiduciary) within 30 days after
19 a final determination regarding the claim pursuant to sec-
20 tion 503.

21 "(b) PLAN INITIATION.—A participant or beneficiary
22 may not commence an action under section 502 with re-
23 spect to any claim until the participant or beneficiary has
24 provided to the plan or the appropriate fiduciary 10 days
25 advance notice of the filing of such action. Within the ear-

1 lier of (1) 25 days after receipt of such a notice with re-
2 spect to any claim or (2) the date preceding the date on
3 which such claim is filed in court, the plan or the appro-
4 priate fiduciary may elect mediation of a dispute under
5 this subpart involving such claim by filing an election for
6 mediation with the Secretary (and a copy of the election
7 with the claimant). Upon a timely election of mediation
8 by the plan or the appropriate fiduciary, the claimant's
9 right to pursue the claim under section 502 shall be sus-
10 pended until the earlier of 75 days after the date of the
11 filing of the election of mediation or the termination of
12 the mediation proceedings.

13 “(c) ELECTION FOR MEDIATION.—An election by any
14 party for mediation under this subpart shall be in such
15 form and manner as the Secretary shall prescribe by regu-
16 lation.

17 “(d) PARTICIPATION.—The claimant and the plan
18 shall participate in the mediation. Each party shall provide
19 the facilitator a written summary of its position with re-
20 spect to the dispute accompanied by supporting docu-
21 mentation.

22 “(e) FILING FEE.—The party initiating mediation
23 under this section shall include with any election for medi-
24 ation under this subpart a reasonable nonrefundable filing
25 fee payable to the Secretary. The filing fee shall be deter-

1 mined pursuant to regulations prescribed by the Sec-
2 retary.

3 “(f) TOLLING OF STATUTES OF LIMITATIONS.—The
4 applicable statute of limitations with respect to any claim
5 involved in a dispute subject to mediation proceedings
6 under this subpart shall be tolled for the period commenc-
7 ing with the 10-day notice period required under sub-
8 section (b) and ending with the termination of the medi-
9 ation proceedings with respect to such dispute. In no event
10 shall the applicable statute of limitations be tolled beyond
11 the 60-day-time limit for completion of mediation provided
12 under section 526.

13 **“SEC. 525. MEDIATION PROCEDURE.**

14 “(a) IN GENERAL.—Mediation proceedings under
15 this subpart shall be conducted, at locations convenient
16 to complainants, by facilitators recruited and assigned by
17 the Secretary under section 522.

18 “(b) DUTIES OF FACILITATOR.—The Secretary shall
19 prescribe by regulation the duties and role of the
20 facilitator during the mediation process. Such regulations
21 may require the facilitator to identify parties, establish a
22 schedule, request position papers from the parties, and
23 evaluate positions of the parties. Such regulations shall
24 provide that the mediation will be informal, convenient,
25 inexpensive, and expeditious for all parties.

1 “(c) NEUTRALITY OF FACILITATOR.—The facilitator
2 shall maintain a neutral stance between the parties.

3 **“SEC. 526. MEDIATION TIME LIMIT.**

4 “Any mediation proceedings commenced under this
5 subpart shall be completed within 60 days from the final
6 appointment of a facilitator pursuant to section 522(c).

7 **“SEC. 527. COST OF MEDIATION.**

8 “All reasonable costs of the mediation process under
9 this subpart with respect to any dispute, including the cost
10 of the facilitator, shall be divided equally among the par-
11 ties. Facilitators shall be compensated at a rate estab-
12 lished by the Secretary by regulation. The Secretary shall
13 prescribe regulations specifying reasonable mediation costs
14 and alternative means of allocating the costs in cases of
15 hardship on the part of the claimant.

16 **“SEC. 528. LEGAL EFFECT OF PARTICIPATION IN MEDI-**
17 **ATION PROGRAM.**

18 “(a) NONBINDING MEDIATION.—The results of any
19 mediation under this subpart shall be treated as advisory
20 in nature and nonbinding. Except as provided in sub-
21 section (b), the rights of the parties shall not be affected
22 by participation in the mediation program.

23 “(b) RESOLUTION THROUGH SETTLEMENT AGREE-
24 MENT.—If a dispute is settled through participation in the
25 mediation program, the facilitator shall, upon the request

1 of either party, assist the parties in drawing up a settle-
2 ment agreement between the parties.

3 **“SEC. 529. CONFIDENTIALITY AND ADMISSIBILITY.**

4 “(a) IN GENERAL.—All documents and communica-
5 tions made during or generated in connection with the me-
6 diation program, as well as any settlement offers or agree-
7 ments made or entered into under such program—

8 “(1) shall be privileged and confidential, and

9 “(2) shall not be admissible as evidence in any
10 Federal or State judicial proceeding unless all par-
11 ties to the mediation consent in writing.

12 “(b) EXECUTION OF PRIVILEGE.—Any individual or
13 entity involved in the mediation (including any party or
14 facilitator or other individual who acts on behalf of a party
15 or who provides information or an opinion in connection
16 with the mediation) receiving a subpoena or other lawful
17 process seeking disclosure of any information or docu-
18 ments rendered privileged and confidential under sub-
19 section (a) shall assert the privilege provided under sub-
20 section (a) and promptly notify all parties to the mediation
21 proceedings of the request for disclosure. The privilege
22 provided for in this section shall be in addition to any at-
23 torney-client privilege or other privilege which may be as-
24 serted by a party and nothing in this section shall con-

1 stitute a waiver of such attorney-client privilege or other
2 privilege.”.

3 (b) CLERICAL AMENDMENTS.—The table of contents
4 in section 1 of such Act is amended—

5 (1) by inserting after the item relating to the
6 heading for part 5 of subtitle B of title I the follow-
7 ing new item:

“Subpart A—General Provisions”;

8 and

9 (2) by inserting after the item relating to sec-
10 tion 514 the following new items:

“Subpart B—Mediation of Group Health Plan Claims

“Sec. 521. Eligibility for submission to mediation.

“Sec. 522. Facilitators.

“Sec. 523. Role of attorneys.

“Sec. 524. Initiation of mediation.

“Sec. 525. Mediation procedure.

“Sec. 526. Mediation time limit.

“Sec. 527. Cost of mediation.

“Sec. 528. Legal effect of participation in mediation program.

“Sec. 529. Confidentiality and admissibility.”.

11 SEC. 1803. AVAILABLE COURT REMEDIES.

12 (a) IN GENERAL.—Section 502(c) of the Employee
13 Retirement Income Security Act of 1974 (29 U.S.C. 1132)
14 is amended by adding at the end the following new para-
15 graphs:

16 “(5) In any action commenced under subsection (a)
17 by a participant or beneficiary with respect to a group
18 health plan in which the plaintiff alleges that a person,

1 in the capacity of a fiduciary and in violation of the terms
2 of the plan or this title, has taken an action resulting in
3 a failure to provide an item or service, or payment there-
4 for, or has failed to take an action for which such person
5 is responsible under the plan and which is necessary under
6 the plan for provision of such item or service, or payment
7 therefor, upon finding in favor of the plaintiff, the court
8 shall cause to be served on the defendant an order requir-
9 ing the defendant—

10 “(i) to cease and desist from the alleged action
11 or failure to act,

12 “(ii) to provide the item or service, or payment
13 therefor, and to otherwise comply with the terms of
14 the plan and the applicable requirements of this
15 title,

16 “(iii) to pay to the plaintiff prejudgment inter-
17 est on the actual costs incurred in obtaining any
18 item or service, or payment therefor, at issue in the
19 complaint, and

20 “(iv) to pay to the plaintiff a reasonable attor-
21 ney’s fee, reasonable expert witness fees, and other
22 reasonable costs relating to the action on the
23 charges on which the plaintiff prevails.

24 The remedies provided under this paragraph shall be in
25 addition to remedies otherwise provided under this section.

1 “(6)(A) The Secretary may assess a civil penalty
2 against the plan administrator of, or the appropriate fidu-
3 ciary (as defined in section 503(b)(5)(K)) of, one or more
4 group health plans for any pattern or practice thereof of
5 repeated failures to provide benefits under the terms of
6 the plan or plans without any reasonable basis or repeated
7 violations thereby of the requirements of section 503 with
8 respect to such plan or plans. Such penalty shall be pay-
9 able only upon proof by clear and convincing evidence of
10 such pattern or practice.

11 “(B) Such penalty shall be in an amount not to ex-
12 ceed the lesser of—

13 “(i) 20 percent of the aggregate value of claims
14 shown by the Secretary to have been denied, or un-
15 lawfully delayed in violation of section 503, under
16 such pattern or practice, or

17 “(ii) \$1,000,000.

18 “(C) The plan administrator or the appropriate fidu-
19 ciary of any group health plan or plans who has engaged
20 in any such pattern or practice with respect to such plans,
21 upon the petition of the Secretary, may be removed by
22 the court from that position, and from any other involve-
23 ment, with respect to such plan or plans, for a period of
24 not less than 7 years.

1 “(D) For purposes of this paragraph, the phrase
2 ‘without any reasonable basis’ means, in connection with
3 any denial of claims for benefits under a group health
4 plan, that such denial does not have any reasonable basis,
5 support, or justification under—

6 “(i) the facts regarding such claim which were
7 reasonably available to the plan administrator or the
8 appropriate fiduciary at the time the claim was de-
9 nied, and

10 “(ii) the terms of the plan.

11 (b) CONFORMING AMENDMENT.—Section 502(a)(6)
12 of such Act (29 U.S.C. 1132(a)(6)) is amended by insert-
13 ing “or (c)(6)” after “(c)(2)”.

14 **SEC. 1804. EFFECTIVE DATE.**

15 The amendments made by this subtitle shall take ef-
16 fect January 1, 1995, except that the Secretary of Labor
17 may issue regulations before such date under such amend-
18 ments. The Secretary shall issue all regulations necessary
19 to carry out the amendments made by this subtitle before
20 the effective date thereof.

1 Subtitle I—Remedies and Enforce-

2 ment With Respect to Group

3 Health Plans

4 SEC. 1801. CLAIMS PROCEDURE FOR GROUP HEALTH

5 PLANS.

6 (a) IN GENERAL.—Section 503 of the Employee Re-

7 tirement Income Security Act of 1974 (29 U.S.C. 1133)

8 is amended—

9 (1) by inserting “(a) IN GENERAL.—” after

10 “SEC. 503.”; and

11 (2) by adding at the end the following new sub-

12 section:

13 “(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

14 “(1) IN GENERAL.—In addition to meeting the

15 requirements of subsection (a), every group health

16 plan shall afford a reasonable opportunity to any

17 participant or beneficiary, whose request for a

18 preauthorization, an emergency preauthorization, a

19 utilization review determination, or an emergency

20 utilization review determination has been denied, for

21 a full and fair review by the appropriate fiduciary of

22 the decision denying the request

23 “(2) TIME LIMITS FOR DECIDING CLAIMS.—

24 “(A) INITIAL DECISIONS.—A group health

25 plan shall issue an initial approval or denial of

1 any claim for medical, surgical, or hospital ben-
2 efits not later than 30 days after its filing com-
3 pletion date. Failure to approve or deny such a
4 claim within such 30-day period shall be treated
5 as a denial of the claim.

6 “(B) REVIEWS OF INITIAL DECISIONS.—
7 Every review by a fiduciary required under
8 paragraph (1) of an initial denial under sub-
9 paragraph (A) shall be completed not later than
10 30 days after the review filing date. Failure to
11 issue a decision affirming, reversing, or modify-
12 ing the initial denial shall be treated as a final
13 decision denying the claim.

14 “(3) TIME LIMIT FOR DECIDING REQUESTS FOR
15 PREAUTHORIZATION.—

16 “(A) GENERAL RULE.—Except as provided
17 in subparagraph (B)—

18 “(i) INITIAL DECISIONS.—If a request
19 for preauthorization is required under the
20 terms of a group health plan, the plan
21 shall approve or deny any such request not
22 later than 30 days after its filing comple-
23 tion date. Failure to approve or deny such
24 a request within such 30-day period shall
25 be treated as a denial of the request.

1 “(ii) REVIEWS OF INITIAL DECI-
2 SIONS.—Every review by a fiduciary re-
3 quired under paragraph (1) of an initial
4 denial under clause (i) shall be completed
5 not later than 30 days after the review fil-
6 ing date. Failure to issue a decision affirm-
7 ing, reversing, or modifying the initial de-
8 nial within such 30-day period shall be
9 treated as a final decision denying the re-
10 quest.

11 “(B) REQUESTS FOR EMERGENCY
12 PREAUTHORIZATION.—

13 “(i) INITIAL DECISIONS.—In any case
14 in which a request for preauthorization re-
15 quired under the terms of a group health
16 plan is a request for emergency
17 preauthorization, the plan shall approve or
18 deny any such request not later than 10
19 days after its filing completion date (24
20 hours after such date in cases involving
21 emergency medical care). Failure to ap-
22 prove or deny such a request within such
23 10-day period (or 24-hour period) shall be
24 treated as a denial of the request.

1 “(ii) REVIEWS OF INITIAL DECI-
2 SIONS.—Every review by a fiduciary re-
3 quired under paragraph (1) of an initial
4 denial under clause (i) shall be completed
5 not later than 10 days after the review fil-
6 ing date (24 hours after such date in cases
7 involving emergency medical care). Failure
8 to issue a decision affirming, reversing, or
9 modifying the initial denial within such 10-
10 day period (or 24-hour period) shall be
11 treated as a final decision denying the re-
12 quest.

13 “(4) TIME LIMIT FOR DECIDING REQUESTS FOR
14 UTILIZATION REVIEW DETERMINATIONS.—

15 “(A) GENERAL RULE.—Except as provided
16 in subparagraph (B)—

17 “(i) INITIAL DECISIONS.—If a request
18 for a utilization review determination is re-
19 quired under the terms of a group health
20 plan, the plan shall approve or deny any
21 such request not later than 30 days after
22 its filing completion date. Failure to ap-
23 prove or deny such a request within such
24 30-day period shall be treated as a denial
25 of the request.

“(ii) **REVIEWS OF INITIAL DECISIONS.**—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial within such 30-day period shall be treated as a final decision denying the request.

“(B) **REQUESTS FOR EMERGENCY UTILIZATION REVIEW DETERMINATIONS.**—

“(i) **INITIAL DECISIONS.**—In any case in which a request for a utilization review determination required under the terms of a group health plan is a request for an emergency utilization review determination, the plan shall approve or deny any such request not later than 10 days after its filing completion date (24 hours after such date in cases involving emergency medical care). Failure to approve or deny such a request within such 10-day period (or 24-hour period) shall be treated as a denial of the request.

1 “(ii) **REVIEWS OF INITIAL DECI-**
2 **SIONS.**—Every review by a fiduciary re-
3 quired under paragraph (1) of an initial
4 denial under clause (i) shall be completed
5 not later than 10 days after the review fil-
6 ing date (24 hours after such date in cases
7 involving emergency medical care). Failure
8 to issue a decision affirming, reversing, or
9 modifying the initial denial within such 10-
10 day period (or 24-hour period) shall be
11 treated as a final decision denying the re-
12 quest.

13 “(5) **DEFINITIONS.**—For purposes of this sub-
14 section—

15 “(A) **CLAIM FOR MEDICAL, SURGICAL, OR**
16 **HOSPITAL BENEFITS.**—The term ‘claim for
17 medical, surgical, or hospital benefits’ means a
18 request for payment by a group health plan of
19 such benefits made by or on behalf of a partici-
20 pant or beneficiary after the expense for medi-
21 cal, surgical, or hospital care has been incurred.

22 “(B) **UTILIZATION REVIEW DETERMINA-**
23 **TION.**—The term ‘utilization review determina-
24 tion’ means a determination under a group
25 health plan solely that proposed medical, sur-

1 gical, or hospital care is medically necessary (as
2 defined in section 1131(7) of the Health Secu-
3 rity Act). Unless otherwise expressly provided
4 under the terms of the plan, any such deter-
5 mination shall not by itself constitute a guaran-
6 tee that benefits under the plan will be pro-
7 vided.

8 “(C) PREAUTHORIZATION.—The term
9 ‘preauthorization’ means a determination under
10 a group health plan that proposed medical, sur-
11 gical, or hospital care meets the plan’s terms
12 and conditions of coverage. Such a determina-
13 tion shall constitute a guarantee that benefits
14 under the plan will be provided.

15 “(D) REQUEST FOR PREAUTHORIZA-
16 TION.—The term ‘request for preauthorization’
17 means a request for preauthorization by a
18 group health plan of medical, surgical, or hos-
19 pital benefits made by or on behalf of a partici-
20 pant or beneficiary before the expense for such
21 care has been incurred.

22 “(E) REQUEST FOR EMERGENCY
23 PREAUTHORIZATION.—The term ‘request for
24 emergency preauthorization’ means a request
25 for preauthorization by a group health plan in

1 any case in which the medical, surgical, or hos-
2 pital benefits for which the expense is to be in-
3 curred constitutes urgent medical care or emer-
4 gency medical care.

5 “(F) REQUEST FOR UTILIZATION REVIEW
6 DETERMINATION.—The term ‘request for a uti-
7 lization review determination’ means a request
8 by or on behalf of a participant or beneficiary,
9 made before an expense for medical, hospital, or
10 surgical care has been incurred, for a utilization
11 review determination by a plan.

12 “(G) REQUEST FOR EMERGENCY UTILIZA-
13 TION REVIEW DETERMINATION.—The term ‘re-
14 quest for an emergency utilization review deter-
15 mination’ means a request for a utilization re-
16 view determination in any case in which the
17 medical, hospital, or surgical care to be in-
18 curred constitutes urgent medical care or emer-
19 gency medical care.

20 “(H) URGENT MEDICAL CARE.—The term
21 ‘urgent medical care’ means medical, surgical,
22 or hospital care in any case in which a physi-
23 cian with appropriate expertise has certified in
24 writing that failure to provide the participant or

beneficiary with such care within 45 days will result in either—

“(i) the death of the participant or beneficiary within 120 days, or

“(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary within 120 days which will significantly increase the reasonable likelihood of death of the participant or beneficiary.

“(I) EMERGENCY MEDICAL CARE.—The term ‘emergency medical care’ means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in writing—

“(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

“(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

1 “(II) serious impairment to bod-
2 ily functions, or

3 “(III) serious dysfunction of any
4 bodily organ or part,

5 or

6 “(ii) that immediate provision of the
7 care is necessary because the participant
8 or beneficiary has made or is at serious
9 risk of making an attempt to harm himself
10 or herself or another individual.

11 “(J) FILING COMPLETION DATE.—The
12 term ‘filing completion date’ means, in connec-
13 tion with a group health plan, the date as of
14 which the plan is in receipt of all information
15 reasonably required to make an initial decision
16 to approve or deny a claim for medical, sur-
17 gical, or hospital benefits, a request for
18 preauthorization, a request for emergency
19 preauthorization, a request for a utilization re-
20 view determination or a request for an emer-
21 gency utilization review determination.

22 “(K) REVIEW FILING DATE.—The term
23 ‘review filing date’ means, in connection with a
24 group health plan, the date as of which the ap-
25 propriate fiduciary is in receipt of all informa-

tion reasonably required to make a decision upon a full and fair review of the denial, in whole or in part, of a claim for medical, surgical, or hospital benefits, a request for preauthorization, a request for emergency preauthorization, a request for a utilization review determination or a request for an emergency utilization review determination.

“(L) APPROPRIATE FIDUCIARY.—The term ‘appropriate fiduciary’ means with respect to any determination under a group health plan a person designated by the plan to make such determination. One or more appropriate fiduciaries shall be designated under each group health plan for making determinations under the plan.”.

(b) DEFINITION OF GROUP HEALTH PLAN.—

(1) IN GENERAL.—Section 3 of such Act (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

“(42) The term ‘group health plan’ means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.”.

1 (2) CONFORMING AMENDMENT.—Section 607
2 of such Act (29 U.S.C. 1167) is amended by striking
3 paragraph (1).

4 **SEC. 1802. MEDIATION OF GROUP HEALTH PLAN CLAIMS.**

5 (a) IN GENERAL.—Part 5 of subtitle B of title I of
6 the Employee Retirement Income Security Act of 1974 is
7 amended—

8 (1) by inserting below the heading for part 5
9 the following:

10 “Subpart A—In General”;

11 and

12 (2) by adding at the end the following new sub-
13 part:

14 “Subpart B—Mediation of Group Health Plan Claims

15 **“SEC. 521. ELIGIBILITY FOR SUBMISSION TO MEDIATION.**

16 “(a) IN GENERAL.—The Secretary shall establish a
17 mediation program under this subpart (hereinafter in this
18 subpart referred to as the ‘mediation program’) for the
19 purpose of facilitating mediation of disputes meeting the
20 requirements specified in subsection (b). At the time no-
21 tice is provided to any participant or beneficiary of a
22 group health plan’s denial of any claim for benefits pursu-
23 ant to section 503, the plan shall provide reasonable notice
24 in writing to the participant or beneficiary whose claim
25 for benefits under the plan has been denied of the avail-

1 ability of mediation under this subpart at the election of
2 either the claimant or the plan.

3 “(b) DISPUTE CRITERIA.—A dispute may be submit-
4 ted for mediation under the mediation program only if the
5 following requirements are met with respect to such dis-
6 pute:

7 “(1) PARTIES.—The dispute consists of an as-
8 sertion by a participant, a beneficiary, or the duly
9 authorized representative of a participant or bene-
10 ficiary (or, in the case of an assignment, the as-
11 signee) of one or more claims under a group health
12 plan, and a denial of such claims, or a denial of ap-
13 propriate reimbursement based on such claims, by
14 such plan or an appropriate fiduciary.

15 “(2) NATURE OF CLAIM.—The claim consists of
16 a claim for benefits for medical, surgical, or hospital
17 expenses under a group health plan which consist of
18 benefits described in section 3(1).

19 “(3) SUBMISSION AFTER EXHAUSTION OF
20 PLAN REMEDIES.—The claimant has received a
21 final determination regarding the claim under the
22 plans’ claims procedure under section 503, or has
23 otherwise exhausted all remedies under the plan pro-
24 vided pursuant to section 503.

1 “(4) APPROPRIATE FIDUCIARY.—For purposes
2 of this subpart, the term ‘appropriate fiduciary’ has
3 the meaning provided in section 503(b)(5)(K).

4 **“SEC. 522. FACILITATORS.**

5 “(a) ROSTER.—The Secretary shall maintain a list
6 of individuals with appropriate expertise to serve as
7 facilitators in proceedings under the mediation program.

8 “(b) CRITERIA.—In identifying individuals to serve
9 as facilitators, the Secretary shall consider the following:

10 “(1) the individual’s experience in dispute reso-
11 lution;

12 “(2) the individual’s ability to act impartially;

13 “(3) the individual’s ability to perform evalua-
14 tions quickly and to present them in nontechnical
15 terms; and

16 “(4) the individual’s experience in employee
17 medical, hospital, and surgical benefits.

18 “(c) APPOINTMENT OF FACILITATOR.—Within 15
19 days after either party files with the Secretary an election
20 of mediation with respect to a dispute, the Secretary shall
21 propose a facilitator, selected under a random selection
22 procedure prescribed in regulations, and notify the parties
23 of such selection. Within 10 days after receipt of the noti-
24 fication of the selection of a facilitator, either party may
25 reject the proposed facilitator. If neither party objects to

1 the Secretary's proposed facilitator within such 10-day pe-
2 riod, the appointment shall become final. If either party
3 objects to the Secretary's proposed facilitator, the proce-
4 dure set forth in the preceding provisions of this sub-
5 section shall be repeated. Each party is limited to 1 objec-
6 tion to the Secretary's proposed facilitator for each medi-
7 ation.

8 **"SEC. 523. ROLE OF ATTORNEYS.**

9 "Parties may represent themselves or be represented
10 by attorneys throughout the mediation process.

11 **"SEC. 524. INITIATION OF MEDIATION.**

12 "(a) CLAIMANT INITIATION.—A claimant may initi-
13 ate mediation of a dispute under this subpart only if no
14 action has been commenced by the claimant under section
15 502 with respect to any claim involved. To initiate medi-
16 ation, a claimant shall file an election for mediation with
17 the Secretary (and shall file a copy of the election with
18 the plan or the appropriate fiduciary) within 30 days after
19 a final determination regarding the claim pursuant to sec-
20 tion 503.

21 "(b) PLAN INITIATION.—A participant or beneficiary
22 may not commence an action under section 502 with re-
23 spect to any claim until the participant or beneficiary has
24 provided to the plan or the appropriate fiduciary 10 days
25 advance notice of the filing of such action. Within the ear-

1 lier of (1) 25 days after receipt of such a notice with re-
2 spect to any claim or (2) the date preceding the date on
3 which such claim is filed in court, the plan or the appro-
4 priate fiduciary may elect mediation of a dispute under
5 this subpart involving such claim by filing an election for
6 mediation with the Secretary (and a copy of the election
7 with the claimant). Upon a timely election of mediation
8 by the plan or the appropriate fiduciary, the claimant's
9 right to pursue the claim under section 502 shall be sus-
10 pended until the earlier of 75 days after the date of the
11 filing of the election of mediation or the termination of
12 the mediation proceedings.

13 “(c) ELECTION FOR MEDIATION.—An election by any
14 party for mediation under this subpart shall be in such
15 form and manner as the Secretary shall prescribe by regu-
16 lation.

17 “(d) PARTICIPATION.—The claimant and the plan
18 shall participate in the mediation. Each party shall provide
19 the facilitator a written summary of its position with re-
20 spect to the dispute accompanied by supporting docu-
21 mentation.

22 “(e) FILING FEE.—The party initiating mediation
23 under this section shall include with any election for medi-
24 ation under this subpart a reasonable nonrefundable filing
25 fee payable to the Secretary. The filing fee shall be deter-

1 mined pursuant to regulations prescribed by the Sec-
2 retary.

3 “(f) TOLLING OF STATUTES OF LIMITATIONS.—The
4 applicable statute of limitations with respect to any claim
5 involved in a dispute subject to mediation proceedings
6 under this subpart shall be tolled for the period commenc-
7 ing with the 10-day notice period required under sub-
8 section (b) and ending with the termination of the medi-
9 ation proceedings with respect to such dispute. In no event
10 shall the applicable statute of limitations be tolled beyond
11 the 60-day-time limit for completion of mediation provided
12 under section 526.

13 **“SEC. 525. MEDIATION PROCEDURE.**

14 “(a) IN GENERAL.—Mediation proceedings under
15 this subpart shall be conducted, at locations convenient
16 to complainants, by facilitators recruited and assigned by
17 the Secretary under section 522.

18 “(b) DUTIES OF FACILITATOR.—The Secretary shall
19 prescribe by regulation the duties and role of the
20 facilitator during the mediation process. Such regulations
21 may require the facilitator to identify parties, establish a
22 schedule, request position papers from the parties, and
23 evaluate positions of the parties. Such regulations shall
24 provide that the mediation will be informal, convenient,
25 inexpensive, and expeditious for all parties.

1 “(c) **NEUTRALITY OF FACILITATOR.**—The facilitator
2 shall maintain a neutral stance between the parties.

3 **“SEC. 526. MEDIATION TIME LIMIT.**

4 “Any mediation proceedings commenced under this
5 subpart shall be completed within 60 days from the final
6 appointment of a facilitator pursuant to section 522(c).

7 **“SEC. 527. COST OF MEDIATION.**

8 “All reasonable costs of the mediation process under
9 this subpart with respect to any dispute, including the cost
10 of the facilitator, shall be divided equally among the par-
11 ties. Facilitators shall be compensated at a rate estab-
12 lished by the Secretary by regulation. The Secretary shall
13 prescribe regulations specifying reasonable mediation costs
14 and alternative means of allocating the costs in cases of
15 hardship on the part of the claimant.

16 **“SEC. 528. LEGAL EFFECT OF PARTICIPATION IN MEDI-**
17 **ATION PROGRAM.**

18 “(a) **NONBINDING MEDIATION.**—The results of any
19 mediation under this subpart shall be treated as advisory
20 in nature and nonbinding. Except as provided in sub-
21 section (b), the rights of the parties shall not be affected
22 by participation in the mediation program.

23 “(b) **RESOLUTION THROUGH SETTLEMENT AGREE-**
24 **MENT.**—If a dispute is settled through participation in the
25 mediation program, the facilitator shall, upon the request

1 of either party, assist the parties in drawing up a settle-
2 ment agreement between the parties.

3 **“SEC. 529. CONFIDENTIALITY AND ADMISSIBILITY.**

4 “(a) IN GENERAL.—All documents and communica-
5 tions made during or generated in connection with the me-
6 diation program, as well as any settlement offers or agree-
7 ments made or entered into under such program—

8 “(1) shall be privileged and confidential, and

9 “(2) shall not be admissible as evidence in any
10 Federal or State judicial proceeding unless all par-
11 ties to the mediation consent in writing.

12 “(b) EXECUTION OF PRIVILEGE.—Any individual or
13 entity involved in the mediation (including any party or
14 facilitator or other individual who acts on behalf of a party
15 or who provides information or an opinion in connection
16 with the mediation) receiving a subpoena or other lawful
17 process seeking disclosure of any information or docu-
18 ments rendered privileged and confidential under sub-
19 section (a) shall assert the privilege provided under sub-
20 section (a) and promptly notify all parties to the mediation
21 proceedings of the request for disclosure. The privilege
22 provided for in this section shall be in addition to any at-
23 torney-client privilege or other privilege which may be as-
24 serted by a party and nothing in this section shall con-

stitute a waiver of such attorney-client privilege or other privilege.”.

(b) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended—

(1) by inserting after the item relating to the heading for part 5 of subtitle B of title I the following new item:

“Subpart A—General Provisions”;

and

(2) by inserting after the item relating to section 514 the following new items:

“Subpart B—Mediation of Group Health Plan Claims

“Sec. 521. Eligibility for submission to mediation.

“Sec. 522. Facilitators.

“Sec. 523. Role of attorneys.

“Sec. 524. Initiation of mediation.

“Sec. 525. Mediation procedure.

“Sec. 526. Mediation time limit.

“Sec. 527. Cost of mediation.

“Sec. 528. Legal effect of participation in mediation program.

“Sec. 529. Confidentiality and admissibility.”.

SEC. 1803. AVAILABLE COURT REMEDIES.

(a) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new paragraphs:

“(5) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms

1 of the plan or this title, has taken an action resulting in
2 a failure to provide an item or service, or payment there-
3 for, or has failed to take an action for which such person
4 is responsible under the plan and which is necessary under
5 the plan for provision of such item or service, or payment
6 therefor, upon finding in favor of the plaintiff, the court
7 shall cause to be served on the defendant an order requir-
8 ing the defendant—

9 “(i) to cease and desist from the alleged action
10 or failure to act,

11 “(ii) to provide the item or service, or payment
12 therefor, and to otherwise comply with the terms of
13 the plan and the applicable requirements of this
14 title,

15 “(iii) to pay to the plaintiff prejudgment inter-
16 est on the actual costs incurred in obtaining any
17 item or service, or payment therefor, at issue in the
18 complaint, and

19 “(iv) to pay to the plaintiff a reasonable attor-
20 ney’s fee, reasonable expert witness fees, and other
21 reasonable costs relating to the action on the
22 charges on which the plaintiff prevails.

23 The remedies provided under this paragraph shall be in
24 addition to remedies otherwise provided under this section.

1 “(6)(A) The Secretary may assess a civil penalty
2 against the plan administrator of, or the appropriate fidu-
3 ciary (as defined in section 503(b)(5)(K)) of, one or more
4 group health plans for any pattern or practice thereof of
5 repeated failures to provide benefits under the terms of
6 the plan or plans without any reasonable basis or repeated
7 violations thereby of the requirements of section 503 with
8 respect to such plan or plans. Such penalty shall be pay-
9 able only upon proof by clear and convincing evidence of
10 such pattern or practice.

11 “(B) Such penalty shall be in an amount not to ex-
12 ceed the lesser of—

13 “(i) 20 percent of the aggregate value of claims
14 shown by the Secretary to have been denied, or un-
15 lawfully delayed in violation of section 503, under
16 such pattern or practice, or

17 “(ii) \$1,000,000.

18 “(C) The plan administrator or the appropriate fidu-
19 ciary of any group health plan or plans who has engaged
20 in any such pattern or practice with respect to such plans,
21 upon the petition of the Secretary, may be removed by
22 the court from that position, and from any other involve-
23 ment, with respect to such plan or plans, for a period of
24 not less than 7 years.

1 “(D) For purposes of this paragraph, the phrase
2 ‘without any reasonable basis’ means, in connection with
3 any denial of claims for benefits under a group health
4 plan, that such denial does not have any reasonable basis,
5 support, or justification under—

6 “(i) the facts regarding such claim which were
7 reasonably available to the plan administrator or the
8 appropriate fiduciary at the time the claim was de-
9 nied, and

10 “(ii) the terms of the plan.

11 (b) CONFORMING AMENDMENT.—Section 502(a)(6)
12 of such Act (29 U.S.C. 1132(a)(6)) is amended by insert-
13 ing “or (c)(6)” after “(c)(2)”.

14 **SEC. 1804. EFFECTIVE DATE.**

15 The amendments made by this subtitle shall take ef-
16 fect January 1, 1995, except that the Secretary of Labor
17 may issue regulations before such date under such amend-
18 ments. The Secretary shall issue all regulations necessary
19 to carry out the amendments made by this subtitle before
20 the effective date thereof.

1 **Subtitle J—Delivery of Health Care** 2 **Services to Illegal Immigrants**

3 **SEC. 1901. STUDY ON THE DELIVERY OF HEALTH CARE** 4 **SERVICES TO ILLEGAL IMMIGRANTS.**

5 (a) IN GENERAL.—As soon as practicable after the
6 date of the enactment of this Act, the Secretary of Health
7 and Human Services shall conduct a detailed study of
8 health care in the United States to populations of individ-
9 uals immigrating to the United States illegally, including
10 the effect of illegal immigration on levels of health costs
11 and the shifting of health costs.

12 (b) MATTERS TO BE ANALYZED.—In conducting the
13 study under this section, the Secretary shall analyze—

14 (1) the extent to which individuals illegally im-
15 migrating into the United States obtain health care
16 services in the United States,

17 (2) the costs of such services,

18 (3) the means currently used to finance such
19 costs,

20 (4) the means currently used for identifying,
21 evaluating, preventing, and resolving health prob-
22 lems of populations comprised of such individuals,

23 (5) the extent of efforts currently being under-
24 taken to prevent or resolve such health problems,

(6) the extent of efforts currently being undertaken to educate populations comprised of such individuals concerning such health problems and to coordinate such efforts,

(7) the programs currently in place for carrying out the activities described in paragraphs (3) through (6), and

(8) the extent of intergovernmental cooperation currently in place between the United States and other countries in dealing with health problems described in the preceding provisions of this subsection.

SEC. 1902. REPORT.

Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to each House of the Congress a final report on the matters analyzed in the study conducted under section 1801. The Secretary shall include in such report any recommendations derived by the Secretary regarding appropriate means of—

(1) alleviating the health problems peculiar to populations of individuals who have immigrated to the United States illegally,

(2) financing health care provided to such populations, and

- 1 (3) increasing intergovernmental cooperation
 2 and coordination of efforts between the United
 3 States and other countries to alleviate such health
 4 problems and to finance such efforts.

5 **TITLE II—HEALTH CARE COST**
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PART 1—ADMINISTRATIVE COST SAVINGS

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1 Subtitle A—Medical Malpractice 2 Liability Reform

3 PART 1—GENERAL PROVISIONS

4 SEC. 2001. FEDERAL REFORM OF MEDICAL MALPRACTICE 5 LIABILITY ACTIONS.

6 (a) APPLICABILITY.—This subtitle shall apply with
7 respect to any medical malpractice liability claim and to
8 any medical malpractice liability action brought in any
9 State or Federal court, except that this subtitle shall not
10 apply to a claim or action for damages arising from a vac-
11 cine-related injury or death to the extent that title XXI

1 of the Public Health Service Act applies to the claim or
2 action.

3 (b) PREEMPTION.—The provisions of this subtitle
4 shall preempt any State law to the extent such law is in-
5 consistent with the limitations contained in such provi-
6 sions. The provisions of this subtitle shall not preempt any
7 State law that provides for defenses or places limitations
8 on a person's liability in addition to those contained in
9 this subtitle, places greater limitations on the amount of
10 attorneys' fees that can be collected, or otherwise imposes
11 greater restrictions than those provided in this subtitle.

12 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
13 OF LAW OR VENUE.—Nothing in subsection (b) shall be
14 construed to—

15 (1) waive or affect any defense of sovereign im-
16 munity asserted by any State under any provision of
17 law;

18 (2) waive or affect any defense of sovereign im-
19 munity asserted by the United States;

20 (3) affect the applicability of any provision of
21 the Foreign Sovereign Immunities Act of 1976;

22 (4) preempt State choice-of-law rules with re-
23 spect to claims brought by a foreign nation or a citi-
24 zen of a foreign nation; or

1 (5) affect the right of any court to transfer
2 venue or to apply the law of a foreign nation or to
3 dismiss a claim of a foreign nation or of a citizen
4 of a foreign nation on the ground of inconvenient
5 forum.

6 (d) **FEDERAL COURT JURISDICTION NOT ESTAB-**
7 **LISHED ON FEDERAL QUESTION GROUNDS.**—Nothing in
8 this subtitle shall be construed to establish any jurisdiction
9 in the district courts of the United States over medical
10 malpractice liability actions on the basis of section 1331
11 or 1337 of title 28, United States Code.

12 **SEC. 2002. DEFINITIONS.**

13 As used in this subtitle:

14 (1) **ALTERNATIVE DISPUTE RESOLUTION SYS-**
15 **TEM; ADR.**—The term “alternative dispute resolu-
16 tion system” or “ADR” means a system established
17 under this subtitle that provides for the resolution of
18 medical malpractice liability claims in a manner
19 other than through medical malpractice liability ac-
20 tions.

21 (2) **CLAIMANT.**—The term “claimant” means
22 any person who alleges a medical malpractice liabil-
23 ity claim, and any person on whose behalf such a
24 claim is alleged, including the decedent in the case

1 of an action brought through or on behalf of an es-
2 tate.

3 (3) CLEAR AND CONVINCING EVIDENCE.—The
4 term “clear and convincing evidence” is that meas-
5 ure or degree of proof that will produce in the mind
6 of the trier of fact a firm belief or conviction as to
7 the truth of the allegations sought to be established,
8 except that such measure or degree of proof is more
9 than that required under preponderance of the evi-
10 dence, but less than that required for proof beyond
11 a reasonable doubt.

12 (4) ECONOMIC DAMAGES.—The term “economic
13 damages” means damages paid to compensate an in-
14 dividual for hospital and other medical expenses, lost
15 wages, lost employment, and other pecuniary losses.

16 (5) HEALTH CARE PROFESSIONAL.—The term
17 “health care professional” means any individual who
18 provides health care services in a State and who is
19 required by the laws or regulations of the State to
20 be licensed or certified by the State to provide such
21 services in the State.

22 (6) HEALTH CARE PROVIDER.—The term
23 “health care provider” means any organization or
24 institution that is engaged in the delivery of health
25 care services in a State and that is required by the

1 laws or regulations of the State to be licensed or cer-
2 tified by the State to engage in the delivery of such
3 services in the State.

4 (7) INJURY.—The term “injury” means any ill-
5 ness, disease, or other harm that is the subject of
6 a medical malpractice liability action or a medical
7 malpractice liability claim.

8 (8) MEDICAL MALPRACTICE LIABILITY AC-
9 TION.—The term “medical malpractice liability ac-
10 tion” means a civil action brought in a State or Fed-
11 eral court against a health care provider or health
12 care professional in which the plaintiff alleges a
13 medical malpractice liability claim, but does not in-
14 clude any action in which the plaintiff’s sole allega-
15 tion is an allegation of an intentional tort.

16 (9) MEDICAL MALPRACTICE LIABILITY
17 CLAIM.—The term “medical malpractice liability
18 claim” means a claim in which the claimant alleges
19 that injury was caused by the provision of (or the
20 failure to provide) health care services or the use of
21 a medical product.

22 (10) MEDICAL PRODUCT.—

23 (A) IN GENERAL.—The term “medical
24 product” means, with respect to the allegation
25 of a claimant, a drug (as defined in section

1 201(g)(1) of the Federal Food, Drug, and Cos-
2 metic Act (21 U.S.C. 321(g)(1)) or a medical
3 device (as defined in section 201(h) of the Fed-
4 eral Food, Drug, and Cosmetic Act (21 U.S.C.
5 321(h)) if—

6 (i) such drug or device was subject to
7 premarket approval under section 505,
8 507, or 515 of the Federal Food, Drug,
9 and Cosmetic Act (21 U.S.C. 355, 357, or
10 360e) or section 351 of the Public Health
11 Service Act (42 U.S.C. 262) with respect
12 to the safety of the formulation or per-
13 formance of the aspect of such drug or de-
14 vice which is the subject of the claimant's
15 allegation or the adequacy of the packag-
16 ing or labeling of such drug or device, and
17 such drug or device is approved by the
18 Food and Drug Administration; or

19 (ii) the drug or device is generally rec-
20 ognized as safe and effective under regula-
21 tions issued by the Secretary of Health
22 and Human Services under section 201(p)
23 of the Federal Food, Drug, and Cosmetic
24 Act (21 U.S.C. 321(p)).

1 (B) EXCEPTION IN CASE OF MISREPRE-
2 SENTATION OR FRAUD.—Notwithstanding sub-
3 paragraph (A), the term “medical product”
4 shall not include any product described in such
5 subparagraph if the claimant shows that the
6 product is approved by the Food and Drug Ad-
7 ministration for marketing as a result of with-
8 held information, misrepresentation, or an ille-
9 gal payment by manufacturer of the product.

10 (11) NONECONOMIC DAMAGES.—The term
11 “noneconomic damages” means damages paid to
12 compensate an individual for physical and emotional
13 pain, suffering, inconvenience, physical impairment,
14 mental anguish, disfigurement, loss of enjoyment of
15 life, loss of consortium, and other nonpecuniary
16 losses, but does not include punitive damages.

17 (12) PUNITIVE DAMAGES; EXEMPLARY DAM-
18 AGES.—The terms “punitive damages” and “exem-
19 plary damages” mean compensation, in addition to
20 compensation for actual harm suffered, that is
21 awarded for the purpose of punishing a person for
22 conduct deemed to be malicious, wanton, willful, or
23 excessively reckless.

24 (13) SECRETARY.—The term “Secretary”
25 means the Secretary of Health and Human Services.

1 (14) STATE.—The term “State” means each of
2 the several States, the District of Columbia, the
3 Commonwealth of Puerto Rico, the Virgin Islands,
4 Guam, and American Samoa.

5 **SEC. 2003. EFFECTIVE DATE.**

6 (a) IN GENERAL.—Except as provided in subsection
7 (b) and section 2017(c), this subtitle shall apply with re-
8 spect to claims accruing or actions brought on or after
9 the expiration of the 3-year period that begins on the date
10 of the enactment of this Act.

11 (b) EXCEPTION FOR STATES REQUESTING EARLIER
12 IMPLEMENTATION OF REFORMS.—

13 (1) APPLICATION.—A State may submit an ap-
14 plication to the Secretary requesting the early imple-
15 mentation of this subtitle with respect to claims or
16 actions brought in the State.

17 (2) DECISION BY SECRETARY.—The Secretary
18 shall issue a response to a State’s application under
19 paragraph (1) not later than 90 days after receiving
20 the application. If the Secretary determines that the
21 State meets the requirements of this subtitle at the
22 time of submitting its application, the Secretary
23 shall approve the State’s application, and this sub-
24 title shall apply with respect to actions brought in
25 the State on or after the expiration of the 90-day

period that begins on the date the Secretary issues the response. If the Secretary denies the State's application, the Secretary shall provide the State with a written explanation of the grounds for the decision.

PART 2—MEDICAL MALPRACTICE AND PRODUCT LIABILITY REFORM

SEC. 2011. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 2032(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 2032(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless

1 the medical malpractice liability claim that is the
2 subject of the action has been initially resolved
3 under the alternative dispute resolution system re-
4 ferred to in paragraph (1) that applied in the State
5 whose law applies in such action.

6 (3) CLAIMS AGAINST UNITED STATES.—

7 (A) ESTABLISHMENT OF PROCESS FOR
8 CLAIMS.—The Attorney General shall establish
9 an alternative dispute resolution process for the
10 resolution of tort claims consisting of medical
11 malpractice liability claims brought against the
12 United States under chapter 171 of title 28,
13 United States Code. Under such process, the
14 resolution of a claim shall occur after the com-
15 pletion of the administrative claim process ap-
16 plicable to the claim under section 2675 of such
17 title.

18 (B) REQUIREMENT FOR INITIAL RESOLU-
19 TION UNDER PROCESS.—A medical malpractice
20 liability action based on a medical malpractice
21 liability claim described in subparagraph (A)
22 may not be brought in any Federal court unless
23 the claim has been initially resolved under the
24 alternative dispute resolution process estab-

1 lished by the Attorney General under such sub-
2 paragraph.

3 (b) INITIAL RESOLUTION OF CLAIMS UNDER
4 ADR.—For purposes of subsection (a), an action is “ini-
5 tially resolved” under an alternative dispute resolution
6 system if—

7 (1) the ADR reaches a decision on whether the
8 defendant is liable to the plaintiff for damages; and

9 (2) if the ADR determines that the defendant
10 is liable, the ADR reaches a decision on the amount
11 of damages assessed against the defendant.

12 (c) PROCEDURES FOR FILING ACTIONS.—

13 (1) NOTICE OF INTENT TO CONTEST DECI-
14 SION.—Not later than 60 days after a decision is is-
15 sued with respect to a medical malpractice liability
16 claim under an alternative dispute resolution system,
17 each party affected by the decision shall submit a
18 sealed statement to a court of competent jurisdiction
19 indicating whether or not the party intends to con-
20 test the decision.

21 (2) DEADLINE FOR FILING ACTION.—A medical
22 malpractice liability action may not be brought by a
23 party unless—

24 (A) the party has filed the notice of intent
25 required by paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—

For purposes of this subsection, the term “court of competent jurisdiction” means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—

The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

1 **SEC. 2012. CALCULATION AND PAYMENT OF DAMAGES.**

2 (a) **LIMITATION ON NONECONOMIC DAMAGES.**—The
3 total amount of noneconomic damages that may be award-
4 ed to a claimant and the members of the claimant's family
5 for losses resulting from the injury which is the subject
6 of a medical malpractice liability action may not exceed
7 \$250,000, regardless of the number of parties against
8 whom the action is brought or the number of actions
9 brought with respect to the injury.

10 (b) **TREATMENT OF PUNITIVE DAMAGES.**—

11 (1) **BASIS FOR RECOVERY.**—Punitive or exem-
12 plary damages shall not be awarded in a medical
13 malpractice liability action unless the claimant es-
14 tablishes by clear and convincing evidence that the
15 injury suffered was the direct result of conduct
16 manifesting a malicious, wanton, willful, or exces-
17 sively reckless disregard of the safety of others.

18 (2) **NO AWARD AGAINST MANUFACTURER OF**
19 **MEDICAL PRODUCT.**—In the case of a medical mal-
20 practice liability action in which the plaintiff alleges
21 a claim against the manufacturer of a medical prod-
22 uct, no punitive or exemplary damages may be
23 awarded against such manufacturer.

24 (3) **PAYMENTS TO STATE FOR MEDICAL QUAL-**
25 **ITY ASSURANCE ACTIVITIES.**—

(A) IN GENERAL.—Any punitive or exemplary damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided.

(B) ACTIVITIES DESCRIBED.—A State shall use amounts paid pursuant to subparagraph (A) to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

(i) licensing or certifying health care professionals and health care providers in the State;

(ii) operating alternative dispute resolution systems;

(iii) carrying out public education programs relating to medical malpractice and the availability of alternative dispute resolution systems in the State; and

(iv) carrying out programs to reduce malpractice-related costs for retired provid-

1 ers or other providers volunteering to pro-
2 vide services in medically underserved
3 areas.

4 (C) MAINTENANCE OF EFFORT.—A State
5 shall use any amounts paid pursuant to sub-
6 paragraph (A) to supplement and not to replace
7 amounts spent by the State for the activities
8 described in subparagraph (B).

9 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

10 (1) GENERAL RULE.—In any medical mal-
11 practice liability action in which the damages award-
12 ed for future economic loss exceeds \$100,000, a de-
13 fendant may not be required to pay such damages
14 in a single, lump-sum payment, but shall be per-
15 mitted to make such payments periodically based on
16 when the damages are found likely to occur, as such
17 payments are determined by the court.

18 (2) WAIVER.—A court may waive the applica-
19 tion of paragraph (1) with respect to a defendant if
20 the court determines that it is not in the best inter-
21 ests of the plaintiff to receive payments for damages
22 on such a periodic basis.

23 (d) MANDATORY OFFSETS FOR DAMAGES PAID BY
24 A COLLATERAL SOURCE.—

1 (1) IN GENERAL.—With respect to a medical
2 malpractice liability claim or action, the total
3 amount of damages received by an individual under
4 such claim or action shall be reduced, in accordance
5 with paragraph (2), by any other payment that has
6 been, or will be, made to an individual to com-
7 pensate such individual for the injury that was the
8 subject of such claim or action.

9 (2) AMOUNT OF REDUCTION.—The amount by
10 which an award of damages to an individual for an
11 injury shall be reduced under paragraph (1) shall
12 be—

13 (A) the total amount of any payments
14 (other than such award) that have been made
15 or that will be made to such individual to pay
16 costs of or compensate such individual for the
17 injury that was the subject of the claim or ac-
18 tion; minus

19 (B) the amount paid by such individual (or
20 by the spouse, parent, or legal guardian of such
21 individual) to secure the payments described in
22 subparagraph (A).

1 **SEC. 2013. TREATMENT OF ATTORNEY'S FEES AND OTHER**
2 **COSTS.**

3 (a) **LIMITATION ON AMOUNT OF CONTINGENCY**
4 **FEES.—**

5 (1) **IN GENERAL.**—An attorney who represents,
6 on a contingency fee basis, a claimant in a medical
7 malpractice liability claim may not charge, demand,
8 receive, or collect for services rendered in connection
9 with such claim in excess of the following amount re-
10 covered by judgment or settlement under such claim:

11 (A) 25 percent of the first \$150,000 (or
12 portion thereof) recovered, plus

13 (B) 10 percent of any amount in excess of
14 \$150,000 recovered.

15 (2) **CALCULATION OF PERIODIC PAYMENTS.**—In
16 the event that a judgment or settlement includes
17 periodic or future payments of damages, the amount
18 recovered for purposes of computing the limitation
19 on the contingency fee under paragraph (1) shall be
20 based on the cost of the annuity or trust established
21 to make the payments. In any case in which an an-
22 nuity or trust is not established to make such pay-
23 ments, such amount shall be based on the present
24 value of the payments.

25 (b) **REQUIRING PARTY CONTESTING ADR RULING**
26 **TO PAY ATTORNEY'S FEES AND OTHER COSTS.—**

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 2011(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action does not exceed the amount of damages awarded to the party under the ADR system by at least 10 percent; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is not at least 10 per-

1 cent less than the amount of damages assessed
2 under the ADR system.

3 (2) EXCEPTIONS.—Paragraph (1) shall not
4 apply if—

5 (A) the party contesting the ruling made
6 under the previous alternative dispute resolu-
7 tion system shows that—

8 (i) the ruling was procured by corrup-
9 tion, fraud, or undue means,

10 (ii) there was partiality or corruption
11 under the system,

12 (iii) there was other misconduct under
13 the system that materially prejudiced the
14 party's rights, or

15 (iv) the ruling was based on an error
16 of law;

17 (B) the party contesting the ruling made
18 under the alternative dispute resolution system
19 presents new evidence before the trier of fact
20 that was not available for presentation under
21 the ADR system;

22 (C) the medical malpractice liability action
23 raised a novel issue of law; or

24 (D) the court finds that the application of
25 such paragraph to a party would constitute an

undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(3) REQUIREMENT FOR PERFORMANCE BOND.—The court in a medical malpractice liability action shall require the party that (pursuant to section 2011(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to post a performance bond (in such amount and consisting of such funds and assets as the court determines to be appropriate), except that the court may waive the application of such requirement to a party if the court determines that the posting of such a bond is not necessary to ensure that the party shall meet the requirements of this subsection to pay the opposing party the costs incurred by the opposing party under the action.

(4) LIMIT ON ATTORNEY'S FEES PAID.—Attorneys' fees that are required to be paid under paragraph (1) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency

1 fee agreement, the amount of attorneys' fees for
2 purposes of the preceding sentence shall not exceed
3 the reasonable value of those services.

4 (5) RECORDS.—In order to receive attorneys'
5 fees under paragraph (1), counsel of record in the
6 medical malpractice liability action involved shall
7 maintain accurate, complete records of hours worked
8 on the action, regardless of the fee arrangement
9 with the client involved.

10 (c) CONTINGENCY FEE DEFINED.—As used in this
11 section, the term “contingency fee” means any fee for pro-
12 fessional legal services which is, in whole or in part, con-
13 tingent upon the recovery of any amount of damages,
14 whether through judgment or settlement.

15 **SEC. 2014. JOINT AND SEVERAL LIABILITY.**

16 A defendant may be held severally but not jointly lia-
17 ble in a medical malpractice action. A person found liable
18 for damages in any such action may be found liable, if
19 at all, only for those damages directly attributable to the
20 person's proportionate share of fault or responsibility for
21 the injury, and may not be found liable for damages at-
22 tributable to the proportionate share of fault or respon-
23 sibility of any other person (without regard to whether
24 that person is a party to the action) for the injury, includ-
25 ing any person bringing the action.

1 **SEC. 2015. STATUTE OF LIMITATIONS.**

2 A medical malpractice liability claim may not be
3 brought after the expiration of the 7-year period that be-
4 gins on the date the alleged injury that is the subject of
5 the claim occurred. If the commencement of such an ac-
6 tion is stayed or enjoined, the running of the statute of
7 limitations under this section shall be suspended for the
8 period of the stay or injunction.

9 **SEC. 2016. UNIFORM STANDARD FOR DETERMINING NEG-**
10 **LIGENCE.**

11 A defendant in a medical malpractice liability action
12 may not be found to have acted negligently unless the de-
13 fendant's conduct at the time of providing the health care
14 services that are the subject of the action was not reason-
15 able.

16 **SEC. 2017. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**
17 **SERVICES.**

18 (a) IMPOSITION OF HIGHER STANDARD OF PROOF.—
19 In the case of a medical malpractice liability claim relating
20 to services provided during labor or the delivery of a baby,
21 if the health care professional against whom the claim is
22 brought did not previously treat the individual alleged to
23 have been injured for the pregnancy, the trier of fact may
24 not find that the defendant committed malpractice and
25 may not assess damages against the health care profes-

1 sional unless the malpractice is proven by clear and con-
 2 vincing evidence.

3 (b) **APPLICABILITY TO GROUP PRACTICES OR**
 4 **AGREEMENTS AMONG PROVIDERS.**—For purposes of sub-
 5 section (a), a health care professional shall be considered
 6 to have previously treated an individual for a pregnancy
 7 if the professional is a member of a group practice whose
 8 members previously treated the individual for the preg-
 9 nancy or is providing services to the individual during
 10 labor or the delivery of a baby pursuant to an agreement
 11 with another health care professional.

12 (c) **EFFECTIVE DATE.**—This section shall apply with
 13 respect to claims accruing or actions brought on or after
 14 the expiration of the 2-year period that begins on the date
 15 of the enactment of this Act.

16 **PART 3—REQUIREMENTS FOR STATE ALTER-**
 17 **NATIVE DISPUTE RESOLUTION SYSTEMS**
 18 **(ADR)**

19 **SEC. 2031. BASIC REQUIREMENTS.**

20 (a) **IN GENERAL.**—A State's alternative dispute reso-
 21 lution system meets the requirements of this section if the
 22 system—

23 (1) applies to all medical malpractice liability
 24 claims under the jurisdiction of the courts of that
 25 State;

1 (2) requires that a written opinion resolving the
2 dispute be issued not later than 6 months after the
3 date by which each party against whom the claim is
4 filed has received notice of the claim (other than in
5 exceptional cases for which a longer period is re-
6 quired for the issuance of such an opinion), and that
7 the opinion contain—

8 (A) findings of fact relating to the dispute,

9 and

10 (B) a description of the costs incurred in
11 resolving the dispute under the system (includ-
12 ing any fees paid to the individuals hearing and
13 resolving the claim), together with an appro-
14 priate assessment of the costs against any of
15 the parties;

16 (3) requires individuals who hear and resolve
17 claims under the system to meet such qualifications
18 as the State may require (in accordance with regula-
19 tions of the Secretary);

20 (4) is approved by the State or by local govern-
21 ments in the State;

22 (5) with respect to a State system that consists
23 of multiple dispute resolution procedures—

1 (A) permits the parties to a dispute to se-
2 lect the procedure to be used for the resolution
3 of the dispute under the system, and

4 (B) if the parties do not agree on the pro-
5 cedure to be used for the resolution of the dis-
6 pute, assigns a particular procedure to the par-
7 ties;

8 (6) provides for the transmittal to the State
9 agency responsible for monitoring or disciplining
10 health care professionals and health care providers
11 of any findings made under the system that such a
12 professional or provider committed malpractice, un-
13 less, during the 90-day period beginning on the date
14 the system resolves the claim against the profes-
15 sional or provider, the professional or provider
16 brings an action contesting the decision made under
17 the system; and

18 (7) provides for the regular transmittal to the
19 Administrator for Health Care Policy and Research
20 of information on disputes resolved under the sys-
21 tem, in a manner that assures that the identity of
22 the parties to a dispute shall not be revealed.

23 (b) APPLICATION OF MALPRACTICE LIABILITY
24 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—
25 The provisions of part 2 shall apply with respect to claims

1 brought under a State alternative dispute resolution sys-
2 tem or the alternative Federal system in the same manner
3 as such provisions apply with respect to medical mal-
4 practice liability actions brought in the State.

5 **SEC. 2032. CERTIFICATION OF STATE SYSTEMS; APPLICA-**
6 **BILITY OF ALTERNATIVE FEDERAL SYSTEM.**

7 (a) CERTIFICATION.—

8 (1) IN GENERAL.—Not later than October 1 of
9 each year (beginning with 1995), the Secretary, in
10 consultation with the Attorney General, shall deter-
11 mine whether a State's alternative dispute resolution
12 system meets the requirements of this part for the
13 following calendar year.

14 (2) BASIS FOR CERTIFICATION.—The Secretary
15 shall certify a State's alternative dispute resolution
16 system under this subsection for a calendar year if
17 the Secretary determines under paragraph (1) that
18 the system meets the requirements of section 2031.

19 (b) APPLICABILITY OF ALTERNATIVE FEDERAL SYS-
20 TEM.—

21 (1) ESTABLISHMENT AND APPLICABILITY.—
22 Not later than October 1, 1995, the Secretary, in
23 consultation with the Attorney General, shall estab-
24 lish by rule an alternative Federal ADR system for
25 the resolution of medical malpractice liability claims

1 during a calendar year in States that do not have
2 in effect an alternative dispute resolution system
3 certified under subsection (a) for the year.

4 (2) REQUIREMENTS FOR SYSTEM.—Under the
5 alternative Federal ADR system established under
6 paragraph (1)—

7 (A) paragraphs (1), (2), (6), and (7) of
8 section 2031(a) shall apply to claims brought
9 under the system;

10 (B) if the system provides for the resolu-
11 tion of claims through arbitration, the claims
12 brought under the system shall be heard and
13 resolved by arbitrators appointed by the Sec-
14 retary in consultation with the Attorney Gen-
15 eral; and

16 (C) with respect to a State in which the
17 system is in effect, the Secretary may (at the
18 State's request) modify the system to take into
19 account the existence of dispute resolution pro-
20 cedures in the State that affect the resolution
21 of medical malpractice liability claims.

22 (3) TREATMENT OF STATES WITH ALTER-
23 NATIVE SYSTEM IN EFFECT.—If the alternative Fed-
24 eral ADR system established under this subsection is
25 applied with respect to a State for a calendar year—

(A) the State shall reimburse the United States (at such time and in such manner as the Secretary may require) for the costs incurred by the United States during the year as a result of the application of the system with respect to the State; and

(B) notwithstanding any other provision of law, no funds may be paid to the State (or to any unit of local government in the State) or to any entity in the State pursuant to the Public Health Service Act.

SEC. 2033. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part and the alternative Federal system established under section 2032(b).

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

1 (A) the effect of the alternative dispute
 2 resolution systems on the cost of health care
 3 within each State,

4 (B) the impact of such systems on the ac-
 5 cess of individuals to health care within the
 6 State, and

7 (C) the effect of such systems on the qual-
 8 ity of health care provided within the State; and

9 (2) to the extent that such report does not pro-
 10 vide information on no-fault systems operated by
 11 States as alternative dispute resolution systems pur-
 12 suant to this part, an analysis of the feasibility and
 13 desirability of establishing a system under which
 14 medical malpractice liability claims shall be resolved
 15 on a no-fault basis.

16 **PART 4—OTHER PROVISIONS RELATING TO**
 17 **MEDICAL MALPRACTICE LIABILITY**

18 **SEC. 2041. PERMITTING STATE PROFESSIONAL SOCIETIES**
 19 **TO PARTICIPATE IN DISCIPLINARY ACTIVI-**
 20 **TIES.**

21 (a) **ROLE OF PROFESSIONAL SOCIETIES.**—Notwith-
 22 standing any other provision of State or Federal law, a
 23 State agency responsible for the conduct of disciplinary
 24 actions for a type of health care practitioner may enter
 25 into agreements with State or county professional societies

1 of such type of health care practitioner to permit such so-
2 cieties to participate in the licensing of such health care
3 practitioner, and to review any health care malpractice ac-
4 tion, health care malpractice claim or allegation, or other
5 information concerning the practice patterns of any such
6 health care practitioner. Any such agreement shall comply
7 with subsection (b).

8 (b) REQUIREMENTS OF AGREEMENTS.—Any agree-
9 ment entered into under subsection (a) for licensing activi-
10 ties or the review of any health care malpractice action,
11 health care malpractice claim or allegation, or other infor-
12 mation concerning the practice patterns of a health care
13 practitioner shall provide that—

14 (1) the health care professional society conducts
15 such activities or review as expeditiously as possible;

16 (2) after the completion of such review, such so-
17 ciety shall report its findings to the State agency
18 with which it entered into such agreement;

19 (3) the conduct of such activities or review and
20 the reporting of such findings be conducted in a
21 manner which assures the preservation of confiden-
22 tiality of health care information and of the review
23 process; and

24 (4) no individual affiliated with such society is
25 liable for any damages or injury directly caused by

1 the individual's actions in conducting such activities
2 or review.

3 (c) AGREEMENTS NOT MANDATORY.—Nothing in
4 this section may be construed to require a State to enter
5 into agreements with societies described in subsection (a)
6 to conduct the activities described in such subsection.

7 (d) EFFECTIVE DATE.—This section shall take effect
8 2 years after the date of the enactment of this Act.

9 **SEC. 2042. STUDY OF INCENTIVES TO ENCOURAGE VOL-**
10 **UNTARY SERVICE BY PHYSICIANS.**

11 (a) STUDY.—The Secretary shall conduct a study
12 analyzing the existence and effectiveness of incentives
13 adopted by State and local governments, insurers, medical
14 societies, and other entities to encourage physicians
15 (whether practicing or retired) to volunteer to provide
16 health care services in medically underserved areas.

17 (b) REPORTS.—(1) Not later than 1 year after the
18 date of the enactment of this Act, the Secretary shall sub-
19 mit an interim report to Congress on the study conducted
20 under subsection (a), together with the Secretary's rec-
21 ommendations for actions to increase the number of physi-
22 cians volunteering to provide health care services in medi-
23 cally underserved areas.

24 (2) Not later than 5 years after the date of the enact-
25 ment of this Act, the Secretary shall submit a final report

1 to the Congress on the study conducted under subsection
2 (a) (taking into account the effects of this subtitle on the
3 incidence and costs of medical malpractice), together with
4 the Secretary's recommendations for actions to increase
5 the number of physicians volunteering to provide health
6 care services in medically underserved areas.

7 **SEC. 2043. REQUIREMENTS FOR RISK MANAGEMENT PRO-**
8 **GRAMS.**

9 (a) **REQUIREMENTS FOR PROVIDERS.**—Each State
10 shall require each health care professional and health care
11 provider providing services in the State to participate in
12 a risk management program to prevent and provide early
13 warning of practices which may result in injuries to pa-
14 tients or which otherwise may endanger patient safety.

15 (b) **REQUIREMENTS FOR INSURERS.**—Each State
16 shall require each entity which provides health care profes-
17 sional or provider liability insurance to health care profes-
18 sionals and health care providers in the State to—

19 (1) establish risk management programs based
20 on data available to such entity or sanction pro-
21 grams of risk management for health care profes-
22 sionals and health care providers provided by other
23 entities; and

24 (2) require each such professional or provider,
25 as a condition of maintaining insurance, to partici-

1 pate in one program described in paragraph (1) at
2 least once in each 3-year period.

3 (c) **EFFECTIVE DATE.**—This section shall take effect
4 2 years after the date of the enactment of this Act.

5 **SEC. 2044. GRANTS FOR MEDICAL SAFETY PROMOTION.**

6 (a) **RESEARCH ON MEDICAL INJURY PREVENTION**
7 **AND COMPENSATION.**

8 (1) **IN GENERAL.**—The Secretary shall make
9 grants for the conduct of basic research in the pre-
10 vention of and compensation for injuries resulting
11 from health care professional or health care provider
12 malpractice, and research of the outcomes of health
13 care procedures.

14 (2) **PREFERENCE FOR RESEARCH ON CERTAIN**
15 **ACTIVITIES.**—In making grants under paragraph
16 (1), the Secretary shall give preference to applica-
17 tions for grants to conduct research on the behavior
18 of health care providers and health care profes-
19 sionals in carrying out their professional duties and
20 of other participants in systems for compensating in-
21 dividuals injured by medical malpractice, the effects
22 of financial and other incentives on such behavior,
23 the determinants of compensation system outcomes,
24 and the costs and benefits of alternative compensa-
25 tion policy options.

1 (3) APPLICATION.—The Secretary may not
2 make a grant under paragraph (1) unless an appli-
3 cant submits an application to the Secretary at such
4 time, in such form, in such manner, and containing
5 such information as the Secretary may require.

6 (b) GRANTS FOR LICENSING AND DISCIPLINARY AC-
7 TIVITIES.—

8 (1) IN GENERAL.—The Secretary shall make
9 grants to States to assist States in improving the
10 State's ability to license and discipline health care
11 professionals.

12 (2) USES FOR GRANTS.—A State may use a
13 grant awarded under subsection (a) to develop and
14 implement improved mechanisms for monitoring the
15 practices of health care professionals or for conduct-
16 ing disciplinary activities.

17 (3) TECHNICAL ASSISTANCE.—The Secretary
18 shall provide technical assistance to States receiving
19 grants under paragraph (1) to assist them in evalu-
20 ating their medical practice acts and procedures and
21 to encourage the use of efficient and effective early
22 warning systems and other mechanisms for detecting
23 practices which endanger patient safety and for dis-
24 ciplining health care professionals.

1 (4) APPLICATIONS.—The Secretary may not
2 make a grant under paragraph (1) unless the appli-
3 cant submits an application to the Secretary at such
4 time, in such form, in such manner, and containing
5 such information as the Secretary shall require.

6 (c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

7 (1) IN GENERAL.—The Secretary shall make
8 grants to States and to local governments, private
9 nonprofit organizations, and health professional
10 schools (as defined in paragraph (3)) for—

11 (A) educating the general public about the
12 appropriate use of health care and realistic ex-
13 pectations of medical intervention;

14 (B) educating the public about the re-
15 sources and role of health care professional li-
16 censing and disciplinary boards in investigating
17 claims of incompetence or health care mal-
18 practice; and

19 (C) developing programs of faculty train-
20 ing and curricula for educating health care pro-
21 fessionals in quality assurance, risk manage-
22 ment, and medical injury prevention.

23 (2) APPLICATIONS.—The Secretary may not
24 make a grant under paragraph (1) unless the appli-
25 cant submits an application to the Secretary at such

time, in such form, in such manner, and containing such information as the Secretary shall require.

(3) HEALTH PROFESSIONAL SCHOOL DEFINED.—In paragraph (1), the term “health professional school” means a school of nursing (as defined in section 853(2) of the Public Health Service Act) or a school or program under section 799(1) of such Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated not more than \$15,000,000 for each of the first 5 fiscal years beginning on or after the date of the enactment of this Act for grants under this section.

Subtitle B—Administrative Cost Savings and Fair Health Information Practices

PART 1—ADMINISTRATIVE COST SAVINGS

SEC. 2100. PURPOSE.

It is the purpose of this part to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act, by encouraging the development of a health information network through the adoption of standards and the

1 establishment of requirements for the electronic trans-
2 mission of certain health information.

3 **SEC. 2101. DEFINITIONS.**

4 For purposes of this part:

5 (1) **CODE SET.**—The term “code set” means
6 any set of codes used for encoding data elements,
7 such as tables of terms, medical concepts, medical
8 diagnostic codes, or medical procedure codes.

9 (2) **COORDINATION OF BENEFITS.**—The term
10 “coordination of benefits” means determining and
11 coordinating the financial obligations of plan spon-
12 sors when health care benefits are payable by more
13 than one such sponsor.

14 (3) **EMPLOYER.**—The term “employer” has the
15 meaning given such term in section 3(5) of the Em-
16 ployee Retirement Income Security Act of 1974.

17 (4) **HEALTH INFORMATION.**—The term “health
18 information” means any information that relates to
19 the past, present, or future physical or mental health
20 or condition or functional status of an individual,
21 the provision of health care to an individual, or pay-
22 ment for the provision of health care to an individ-
23 ual.

24 (5) **HEALTH INFORMATION NETWORK.**—The
25 term “health information network” means the health

1 information system that is formed through the appli-
2 cation of the requirements and standards established
3 under this part.

4 (6) HEALTH INFORMATION NETWORK SERV-
5 ICE.—The term “health information network serv-
6 ice”—

7 (A) means a private entity or an entity op-
8 erated by a State that enters into contracts—

9 (i) to process or facilitate the process-
10 ing of nonstandard data elements of health
11 information into standard data elements;

12 (ii) to provide the means by which
13 persons are connected to the health infor-
14 mation network for purposes of meeting
15 the requirements of this part, including the
16 holding of standard data elements of
17 health information;

18 (iii) to provide authorized access to
19 health information through the health in-
20 formation network; or

21 (iv) to provide specific information
22 processing services, such as automated co-
23 ordination of benefits and claims trans-
24 action routing; and

1 (B) includes a health information protec-
2 tion service.

3 (7) HEALTH INFORMATION PROTECTION SERV-
4 ICE.—The term “health information protection serv-
5 ice” means a private entity or an entity operated by
6 a State that accesses standard data elements of
7 health information through the health information
8 network, processes such information into non-identi-
9 fiable health information, and may store such infor-
10 mation.

11 (8) HEALTH PROVIDER.—The term “health
12 provider” includes a provider of services (as defined
13 in section 1861(u) of the Social Security Act), a pro-
14 vider of medical or other health services (as defined
15 in section 1861(s) of such Act), and any other per-
16 son (other than a plan sponsor) furnishing health
17 care items or services.

18 (9) NON-IDENTIFIABLE HEALTH INFORMA-
19 TION.—The term “non-identifiable health informa-
20 tion” means health information that is not protected
21 health information (as defined in part 2).

22 (10) PLAN SPONSOR.—The term “plan spon-
23 sor” means—

24 (A) a plan (as defined in section
25 1033(6)(B));

(B) an insurer (as defined in section 1131(6)) providing health insurance coverage (as defined in section 1131(4)); and

(C) a State, or the Federal Government, acting in a capacity as a provider of health benefits to eligible individuals that is equivalent to that of an insurer.

(11) PURCHASING ARRANGEMENT.—The term “purchasing arrangement” means a voluntary health purchasing arrangement described in part 3 of subtitle B of title I.

(12) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(13) STANDARD.—The term “standard”, when used with reference to a transaction or to data elements of health information, means that the transaction or data elements meet any standard adopted by the Secretary under subpart A that applies to the transaction or data elements.

Subpart A—Standards for Data Elements and Transactions

SEC. 2103. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this part that are—

1 (1) consistent with the objective of reducing the
2 costs of providing and paying for health care; and

3 (2) in use and generally accepted, developed, or
4 modified by the standard-setting organizations ac-
5 credited by the American National Standard Insti-
6 tute.

7 (b) INITIAL STANDARDS.—The Secretary may de-
8 velop an expedited process for the adoption of initial
9 standards under this subpart.

10 (c) PROTECTION OF COMMERCIAL INFORMATION.—
11 In adopting standards under this part, the Secretary may
12 not require disclosure of trade secrets and confidential
13 commercial information by any person.

14 **SEC. 2104. STANDARDS FOR DATA ELEMENTS OF HEALTH**
15 **INFORMATION.**

16 (a) IN GENERAL.—The Secretary shall adopt stand-
17 ards necessary to make uniform and compatible for elec-
18 tronic transmission through the health information net-
19 work the data elements of any health information that the
20 Secretary determines is appropriate for transmission in
21 connection with a transaction described in section 2111.

22 (b) ADDITIONS.—The Secretary may make additions
23 to any set of data elements adopted under subsection (a)
24 as the Secretary determines appropriate in a manner that

1 minimizes the disruption and cost of compliance with such
2 additions.

3 (c) CERTAIN DATA ELEMENTS.—

4 (1) UNIQUE HEALTH IDENTIFIERS.—The Sec-
5 retary shall establish a system to provide for a
6 standard unique health identifier for each individual,
7 employer, plan sponsor, and health provider for use
8 in the health care system.

9 (2) CODE SETS.—

10 (A) IN GENERAL.—The Secretary, in con-
11 sultation with experts from the private sector
12 and Federal agencies, shall—

13 (i) select code sets for appropriate
14 data elements from among the code sets
15 that have been developed by private and
16 public entities; or

17 (ii) establish code sets for such data
18 elements if no code sets for the data ele-
19 ments have been developed.

20 (B) DISTRIBUTION.—The Secretary shall
21 establish efficient and low-cost procedures for
22 distribution of code sets and modifications to
23 code sets.

1 **SEC. 2105. INFORMATION TRANSACTION STANDARDS.**

2 (a) **IN GENERAL.**—The Secretary shall adopt tech-
3 nical standards that are consistent with part 2 relating
4 to the method by which standard data elements of health
5 information may be transmitted electronically, including
6 standards with respect to the format in which such data
7 elements may be transmitted.

8 (b) **SPECIAL RULE FOR COORDINATION OF BENE-**
9 **FITS.**—Any standard adopted by the Secretary under
10 paragraph (1) that relates to coordination of benefits shall
11 provide that a claim for reimbursement for health services
12 furnished shall be tested, by an algorithm specified by the
13 Secretary, against all records of enrollment and eligibility
14 for the individual who received such services that are avail-
15 able to the recipient of the claim through the health infor-
16 mation network to determine any primary and secondary
17 obligors for payment.

18 (c) **ELECTRONIC SIGNATURE.**—The Secretary, in co-
19 ordination with the Secretary of Commerce, shall promul-
20 gate regulations specifying procedures for the electronic
21 transmission and authentication of signatures, compliance
22 with which shall be deemed to satisfy State and Federal
23 statutory requirements for written signatures with respect
24 to transactions described in section 2111 and written sig-
25 natures on health records and prescriptions.

1 (d) STANDARDS FOR CLAIMS FOR CLINICAL LABORA-
2 TORY TESTS.—The standards under this section shall pro-
3 vide that claims for clinical laboratory tests for which ben-
4 efits are payable by a plan sponsor shall be submitted di-
5 rectly by the person or entity that performed (or super-
6 vised the performance of) the tests to the sponsor in a
7 manner consistent with (and subject to such exceptions
8 as are provided under) the requirement for direct submis-
9 sion of such claims under the medicare program.

10 **SEC. 2106. TIMETABLES FOR ADOPTION OF STANDARDS.**

11 (a) INITIAL STANDARDS FOR DATA ELEMENTS.—
12 The Secretary shall adopt standards relating to—

13 (1) the data elements for the information de-
14 scribed in section 2104(a) not later than 9 months
15 after the date of the enactment of this Act (except
16 in the case of standards with respect to data ele-
17 ments for claims attachments, which shall be adopt-
18 ed not later than 24 months after the date of the
19 enactment of this Act); and

20 (2) any addition to a set of data elements, in
21 conjunction with making such an addition.

22 (b) INITIAL STANDARDS FOR INFORMATION TRANS-
23 ACTIONS.—The Secretary shall adopt standards relating
24 to information transactions under section 2105 not later
25 than 9 months after the date of the enactment of this Act

1 (except in the case of standards for claims attachments,
2 which shall be adopted not later than 24 months after the
3 date of the enactment of this Act).

4 (c) MODIFICATIONS TO STANDARDS.—

5 (1) IN GENERAL.—Except as provided in para-
6 graph (2), the Secretary shall review the standards
7 adopted under this subpart and shall adopt modified
8 standards as determined appropriate, but not more
9 frequently than once every 6 months. Any modifica-
10 tion to standards shall be completed in a manner
11 which minimizes the disruption to, and costs of com-
12 pliance incurred by, a plan sponsor, health provider,
13 or purchasing arrangement that is required to com-
14 ply with subpart B.

15 (2) SPECIAL RULES.—

16 (A) MODIFICATIONS DURING FIRST 12-
17 MONTH PERIOD.—Except with respect to addi-
18 tions and modifications to code sets under sub-
19 paragraph (B), the Secretary may not adopt
20 any modification to a standard adopted under
21 this subpart during the 12-month period begin-
22 ning on the date the standard is adopted, un-
23 less the Secretary determines that the modifica-
24 tion is necessary in order to permit a plan spon-

1 sor, a health provider, or a purchasing arrange-
2 ment to comply with subpart B.

3 (B) ADDITIONS AND MODIFICATIONS TO
4 CODE SETS.—

5 (i) IN GENERAL.—The Secretary shall
6 ensure that procedures exist for the rou-
7 tine maintenance, testing, enhancement,
8 and expansion of code sets.

9 (ii) ADDITIONAL RULES.—If a code
10 set is modified under this subsection, the
11 modified code set shall include instructions
12 on how data elements that were encoded
13 prior to the modification are to be con-
14 verted or translated so as to preserve the
15 value of the data elements. Any modifica-
16 tion to a code set under this subsection
17 shall be implemented in a manner that
18 minimizes the disruption to, and costs of
19 compliance incurred by, a plan sponsor,
20 health provider, or purchasing arrange-
21 ment that is required to comply with sub-
22 part B.

23 (d) EVALUATION OF STANDARDS.—The Secretary
24 may establish a process to measure or verify the consist-
25 ency of standards adopted or modified under this subpart.

1 Such process may include demonstration projects and
2 analyses of the cost of implementing such standards and
3 modifications.

4 **Subpart B—Requirements With Respect to Certain**
5 **Transactions and Information**

6 **SEC. 2111. STANDARD TRANSACTIONS AND INFORMATION.**

7 (a) TRANSACTIONS BY SPONSORS.—

8 (1) TRANSACTIONS WITH PROVIDERS.—If a
9 plan sponsor conducts any of the transactions de-
10 scribed in paragraph (3) with a health provider—

11 (A) the transaction shall be a standard
12 transaction; and

13 (B) the health information transmitted by
14 the sponsor to the provider or by the provider
15 to the sponsor in connection with the trans-
16 action shall be in the form of standard data ele-
17 ments.

18 (2) TRANSACTIONS WITH SPONSORS.—If a plan
19 sponsor conducts any of the transactions described
20 in paragraph (3) with another plan sponsor—

21 (A) the transaction shall be a standard
22 transaction; and

23 (B) the health information transmitted by
24 either sponsor in connection with the trans-

1 action shall be in the form of standard data ele-
2 ments.

3 (3) TRANSACTIONS.—The transactions referred
4 to in paragraphs (1) and (2) are the following:

5 (A) Verification of eligibility for benefits.

6 (B) Coordination of benefits.

7 (C) Claim submission.

8 (D) Claim attachment submission.

9 (E) Claim status notification.

10 (F) Claim status verification.

11 (G) Claim adjudication.

12 (H) Payment and remittance advice.

13 (I) Certification or authorization of a re-
14 ferral to a health provider who is not part of
15 the defined set of providers providing items and
16 services under a network plan (as defined in
17 section 1131(5)).

18 (b) TRANSACTIONS BY PURCHASING ARRANGE-
19 MENTS.—

20 (1) IN GENERAL.—If a purchasing arrangement
21 conducts any of the transactions described in para-
22 graph (2) with a plan sponsor—

23 (A) the transaction shall be a standard
24 transaction; and

1 (B) the health information transmitted by
2 the arrangement to the sponsor or by the spon-
3 sor to the arrangement in connection with the
4 transaction shall be in the form of standard
5 data elements.

6 (2) TRANSACTIONS.—The transactions referred
7 to in paragraph (1) are the following:

8 (A) Enrollment and disenrollment.

9 (B) Premium payment.

10 (c) USE OF HEALTH INFORMATION NETWORK SERV-
11 ICES.—A plan sponsor, a health provider, or a purchasing
12 arrangement may comply with any provision of this sec-
13 tion by entering into an agreement or other arrangement
14 with a health information network service certified under
15 section 2121 pursuant to which the service undertakes the
16 duties applicable to the sponsor, provider, or arrangement
17 under the provision.

18 **SEC. 2112. ACCESSING HEALTH INFORMATION FOR AU-**
19 **THORIZED PURPOSES.**

20 (a) PROCUREMENT RULE FOR GOVERNMENT AGEN-
21 CIES.—

22 (1) IN GENERAL.—A health information protec-
23 tion service that is certified under section 2121 shall
24 make available to a Federal or State agency, pursu-
25 ant to a cost-type contract (as defined under the

Federal Acquisition Regulation), any non-identifiable health information, including non-identifiable health information that is derived from protected health information, that—

(A) is held by the service or may be obtained by the service under paragraph (2) or subsection (b);

(B) consists of data elements that are subject to a standard under subpart A; and

(C) is requested by the agency to fulfill a requirement under this Act.

(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information protection service requires health information consisting of data elements that are subject to a standard under subpart A from a plan sponsor or a health provider in order to comply with a request made by a Federal or State agency under paragraph (1), the sponsor or provider shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information.

(b) PROCUREMENT RULE FOR INFORMATION PROTECTION SERVICES.—A health information protection service that makes non-identifiable health information available to a Federal or State agency under subsection

1 (a) shall make such non-identifiable information available,
 2 for a charge that does not exceed the reasonable cost of
 3 transmitting the information, to any other health informa-
 4 tion protection service that—

5 (A) is certified under section 2121; and

6 (B) requests the information.

7 **SEC. 2113. ENSURING AVAILABILITY OF INFORMATION.**

8 The Secretary shall establish a procedure under
 9 which a plan sponsor or health provider that does not have
 10 the ability to transmit standard data elements directly,
 11 and does not have access to a health information network
 12 service certified under section 2121, may comply with the
 13 provisions of this subpart.

14 **SEC. 2114. TIMETABLES FOR COMPLIANCE WITH REQUIRE-**
 15 **MENTS.**

16 (a) INITIAL COMPLIANCE.—

17 (1) IN GENERAL.—Not later than 12 months
 18 after the date on which standards are adopted under
 19 subpart A with respect to a type of transaction, or
 20 data elements for a type of health information, a
 21 plan sponsor, health provider, or purchasing ar-
 22 rangement shall comply with the requirements of
 23 this subpart with respect to such transaction or in-
 24 formation.

1 (2) ADDITIONAL DATA ELEMENTS.—Not later
2 than 12 months after the date on which the Sec-
3 retary adopts an addition to a set of data elements
4 for health information under section 2104, a plan
5 sponsor, health provider, or purchasing arrangement
6 shall comply with the requirements of this subpart
7 using such data elements.

8 (b) COMPLIANCE WITH MODIFIED STANDARDS.—

9 (1) IN GENERAL.—If the Secretary adopts a
10 modified standard under section 2106(c), a plan
11 sponsor, health provider, or purchasing arrangement
12 shall comply with the modified standard at such
13 time as the Secretary determines appropriate, taking
14 into account the time needed to comply due to the
15 nature and extent of the modification.

16 (2) SPECIAL RULE.—In the case of a modifica-
17 tion to a standard that does not occur within the 12-
18 month period beginning on the date the standard is
19 adopted, the time determined appropriate by the
20 Secretary under paragraph (1) may not be—

21 (A) earlier than the last day of the 90-day
22 period beginning on the date the modified
23 standard is adopted; or

1 (B) later than the last day of the 12-
2 month period beginning on the date the modi-
3 fied standard is adopted.

4 **Subpart C—Miscellaneous Provisions**

5 **SEC. 2121. STANDARDS AND CERTIFICATION FOR HEALTH**
6 **INFORMATION NETWORK SERVICES.**

7 (a) STANDARDS FOR OPERATION.—The Secretary
8 shall establish standards with respect to the operation of
9 health information network services, including standards
10 ensuring that such services—

11 (1) develop, operate, and cooperate with one an-
12 other to form the health information network;

13 (2) meet all of the requirements under part 2
14 that are applicable to the services;

15 (3) make public information concerning their
16 performance, as measured by uniform indicators
17 such as accessibility, transaction responsiveness, ad-
18 ministrative efficiency, reliability, dependability, and
19 any other indicator determined appropriate by the
20 Secretary;

21 (4) have security procedures that are consistent
22 with the requirements under part 2, including secure
23 methods of accessing and transmitting data; and

24 (5) if they are part of a larger organization,
25 have policies and procedures in place which isolate

1 their activities with respect to processing informa-
2 tion in a manner that prevents access to such infor-
3 mation by such larger organization.

4 (b) CERTIFICATION BY THE SECRETARY.—

5 (1) ESTABLISHMENT.—Not later than 12
6 months after the date of the enactment of this Act,
7 the Secretary shall establish a certification proce-
8 dure for health information network services which
9 ensures that certified services are qualified to meet
10 the requirements of this part and the standards es-
11 tablished by the Secretary under this section. Such
12 certification procedure shall be implemented in a
13 manner that minimizes the costs and delays of oper-
14 ations for such services.

15 (2) APPLICATION.—Each entity desiring to be
16 certified as a health information network service
17 shall apply to the Secretary for certification in a
18 form and manner determined appropriate by the
19 Secretary.

20 (3) AUDITS AND REPORTS.—The procedure es-
21 tablished under paragraph (1) shall provide for au-
22 dits by the Secretary and reports by an entity cer-
23 tified under this section as the Secretary determines
24 appropriate in order to monitor such entity's compli-
25 ance with the requirements of this part, part 2, and

1 the standards established by the Secretary under
2 this section.

3 (4) RECERTIFICATION.—A health information
4 network service shall be recertified under this sub-
5 section at least every 3 years.

6 (c) LOSS OF CERTIFICATION.—

7 (1) MANDATORY TERMINATION.—Except as
8 provided in paragraph (2), if a health information
9 network service violates a requirement imposed on
10 such service under part 2, its certification under this
11 section shall be terminated unless the Secretary de-
12 termines that appropriate corrective action has been
13 taken.

14 (2) CONDITIONAL CERTIFICATION—The Sec-
15 retary may establish a procedure under which a
16 health information network service may remain cer-
17 tified on a conditional basis if the service is operat-
18 ing consistently with a plan intended to correct any
19 violations described in paragraph (1). Such proce-
20 dure may provide for the appointment of a trustee
21 to continue operation of the service until the require-
22 ments for full certification are met.

23 (d) CERTIFICATION BY PRIVATE ENTITIES.—The
24 Secretary may designate private entities to conduct the
25 certification procedures established by the Secretary under

1 this section. A health information network service certified
2 by such an entity in accordance with such designation
3 shall be considered to be certified by the Secretary.

4 (e) INFORMATION HELD BY HEALTH INFORMATION
5 NETWORK SERVICES.—If a health information network
6 service certified under this section loses its certified status
7 or takes any action that would threaten the continued
8 availability of the standard data elements of health infor-
9 mation held by such service, such data elements shall be
10 transferred to another health information network service
11 certified under this section that has been designated by
12 the Secretary.

13 **SEC. 2122. IMPOSITION OF ADDITIONAL REQUIREMENTS.**

14 (a) IN GENERAL.—Except as provided in subsection
15 (c), after the Secretary has established standards under
16 section 2104 that are necessary to make uniform and com-
17 patible for electronic transmission the data elements that
18 the Secretary determines are appropriate for transmission
19 in connection with a transaction described in subpart B,
20 an individual or entity may not require an individual or
21 entity, to provide in any manner any additional data ele-
22 ment in connection with—

23 (1) the transaction; or

24 (2) an inquiry with respect to the transaction.

1 (b) TRANSMISSION METHOD.—Except as provided in
 2 subsection (c), after the Secretary has established stand-
 3 ards under section 2105 relating to the method by which
 4 data elements that the Secretary determines are appro-
 5 priate for transmission in connection with a transaction
 6 described in subpart B may be transmitted electronically,
 7 an individual or entity may not require an individual or
 8 entity to transmit any data element in a manner inconsis-
 9 ent with the standards in connection with—

10 (1) the transaction; or

11 (2) an inquiry with respect to the transaction.

12 (c) EXCEPTION.—Subsections (a) and (b) do not
 13 apply if—

14 (1) an individual or entity voluntarily agrees to
 15 provide the additional data element; or

16 (2) a waiver is granted under subsection (d) to
 17 permit the requirement.

18 (d) CONDITIONS FOR WAIVERS.—

19 (1) IN GENERAL.—An individual or entity may
 20 request a waiver from the Secretary in order to im-
 21 pose on an individual or entity a requirement other-
 22 wise prohibited under subsection (a) or (b).

23 (2) CONSIDERATION OF WAIVER REQUESTS.—A
 24 waiver may not be granted under this subsection to
 25 impose an otherwise prohibited requirement unless

1 the Secretary determines that the value of any addi-
2 tional information to be provided under the require-
3 ment for research or other purposes significantly
4 outweighs the administrative cost of the imposition
5 of the requirement, taking into account the burden
6 of the timing of the imposition of the requirement.

7 (3) ANONYMOUS REPORTING.—If an individual
8 or entity attempts to impose on an individual or en-
9 tity a requirement prohibited under subsection (a) or
10 (b), the individual or entity on whom the require-
11 ment is being imposed may contact the Secretary.
12 The Secretary shall develop a procedure under which
13 an individual or entity that contacts the Secretary
14 under the preceding sentence shall remain anony-
15 mous. The Secretary shall notify the individual or
16 entity imposing the requirement that the require-
17 ment may not be imposed unless the other individual
18 or entity voluntarily agrees to such requirement or
19 a waiver is obtained under this subsection.

20 **SEC. 2123. EFFECT ON STATE LAW.**

21 (a) IN GENERAL.—Except as otherwise provided in
22 this section, a provision, requirement, or standard under
23 this part shall supersede any contrary provision of State
24 law.

1 (b) STATE “QUILL AND PEN” LAWS.—A State may
2 not establish, continue in effect, or enforce any provision
3 of State law that requires medical or health plan records
4 (including billing information) to be maintained or trans-
5 mitted in written rather than electronic form, except
6 where the Secretary determines that the provision is nec-
7 essary to prevent fraud and abuse, with respect to con-
8 trolled substances, or for other purposes.

9 (c) PUBLIC HEALTH REPORTING.—Nothing in this
10 part shall be construed to invalidate or limit the authority,
11 power, or procedures established under any law providing
12 for the reporting of disease or injury, child abuse, birth,
13 or death, public health surveillance, or public health inves-
14 tigation or intervention.

15 (d) PUBLIC USE FUNCTIONS.—Nothing in this part
16 shall be construed to limit the authority of a Federal or
17 State agency to make non-identifiable health information
18 available for public use.

19 (e) PAYMENT FOR HEALTH CARE SERVICES OR PRE-
20 MIUMS.—Nothing in this part shall be construed to pro-
21 hibit a consumer from paying for health care items or
22 services, or plan or health insurance coverage premiums,
23 by debit, credit, or other payment cards or numbers or
24 other electronic payment means.

1 **SEC. 2124. GRANTS FOR DEMONSTRATION PROJECTS.**

2 (a) IN GENERAL.—The Secretary may make grants
3 for demonstration projects to promote the development
4 and use of electronically integrated community-based clini-
5 cal information systems and computerized patient medical
6 records.

7 (b) APPLICATIONS.—

8 (1) SUBMISSION.—To apply for a grant under
9 this section for any fiscal year, an applicant shall
10 submit an application to the Secretary in accordance
11 with the procedures established by the Secretary.

12 (2) CRITERIA FOR APPROVAL.—The Secretary
13 may not approve an application submitted under
14 paragraph (1) unless the application includes assur-
15 ances satisfactory to the Secretary regarding the fol-
16 lowing:

17 (A) USE OF EXISTING TECHNOLOGY.—

18 Funds received under this section will be used
19 to apply telecommunications and information
20 systems technology that is in existence on the
21 date the application is submitted in a manner
22 that improves the quality of health care, re-
23 duces the costs of such care, and protects the
24 privacy and confidentiality of information relat-
25 ing to the physical or mental condition of an in-
26 dividual.

1 (B) USE OF EXISTING INFORMATION SYS-
2 TEMS.—Funds received under this section will
3 be used—

4 (i) to enhance telecommunications or
5 information systems that are operating on
6 the date the application is submitted;

7 (ii) to integrate telecommunications or
8 information systems that are operating on
9 the date the application is submitted; or

10 (iii) to connect additional users to
11 telecommunications or information net-
12 works or systems that are operating on the
13 date the application is submitted.

14 (C) MATCHING FUNDS.—The applicant
15 shall make available funds for the demonstra-
16 tion project in an amount that equals at least
17 20 percent of the cost of the project.

18 (c) GEOGRAPHIC DIVERSITY.—In making any grants
19 under this section, the Secretary shall, to the extent prac-
20 ticable, make grants to persons representing different geo-
21 graphic areas of the United States, including urban and
22 rural areas.

23 (d) REVIEW AND SANCTIONS.—The Secretary shall
24 review at least annually the compliance of a person receiv-
25 ing a grant under this section with the provisions of this

1 section. The Secretary shall establish a procedure for de-
 2 termining whether such a person has failed to comply sub-
 3 stantially within the provisions of this section and the
 4 sanctions to be imposed for any such noncompliance.

5 (e) ANNUAL REPORT.—The Secretary shall submit
 6 an annual report to the President for transmittal to Con-
 7 gress containing a description of the activities carried out
 8 under this section.

9 **Subpart D—Assistance to the Secretary**

10 **SEC. 2131. GENERAL REQUIREMENT ON SECRETARY.**

11 In complying with any requirements imposed on the
 12 Secretary under this part, the Secretary shall rely on rec-
 13 ommendations of the Health Information Advisory Com-
 14 mittee established under section 2132 and shall consult
 15 with appropriate Federal agencies.

16 **SEC. 2132. HEALTH INFORMATION ADVISORY COMMITTEE.**

17 (a) ESTABLISHMENT.—There is established a com-
 18 mittee to be known as the Health Care Information Advi-
 19 sory Committee.

20 (b) DUTY.—

21 (1) IN GENERAL.—The committee shall—

22 (A) provide assistance to the Secretary in
 23 complying with the requirements imposed on
 24 the Secretary under this part and part 2;

1 (B) be generally responsible for advising
2 the Secretary and the Congress on the status of
3 the health information network; and

4 (C) make recommendations to correct any
5 problems that may occur in the network's im-
6 plementation and ongoing operations and to re-
7 fine and improve the network.

8 (2) TECHNICAL ASSISTANCE.—In performing
9 its duties under this subsection, the committee shall
10 receive technical assistance from appropriate Federal
11 agencies.

12 (c) MEMBERSHIP.—

13 (1) IN GENERAL.—The committee shall consist
14 of 15 members to be appointed by the President not
15 later than 60 days after the date of the enactment
16 of this part. The President shall designate 1 member
17 as the Chair.

18 (2) EXPERTISE.—The membership of the com-
19 mittee shall consist of individuals who are of recog-
20 nized standing and distinction and who possess the
21 demonstrated capacity to discharge the duties im-
22 posed on the committee.

23 (3) TERMS.—Each member of the committee
24 shall be appointed for a term of 5 years, except that
25 the members first appointed shall serve staggered

terms such that the terms of no more than 3 members expire at one time.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(5) CONFLICTS OF INTEREST.—Members of the committee shall disclose upon appointment to the committee or at any subsequent time that it may occur, conflicts of interest.

(d) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the committee shall meet at the call of the Chair.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the commit-

tee have been appointed, the committee shall hold its first meeting.

(3) QUORUM.—A majority of the members of the committee shall constitute a quorum, but a lesser number of members may hold hearings.

(e) POWER TO HOLD HEARINGS.—The committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the committee considers advisable to carry out the purposes of this section.

(f) OTHER ADMINISTRATIVE PROVISIONS.—Subparagraphs (C), (D), and (H) of section 1886(e)(6) of the Social Security Act shall apply to the committee in the same manner as they apply to the Prospective Payment Assessment Commission.

(g) REPORTS.—

(1) IN GENERAL.—The committee shall annually prepare and submit to Congress and the Secretary a report including at least an analysis of—

(A) the status of the health information network established under this part, including whether the network is fulfilling the purpose described in section 2100;

(B) the savings and costs of the network;

1 (C) the activities of health information net-
2 work services certified under section 2121,
3 health providers, and plan sponsors under this
4 part;

5 (D) the extent to which entities described
6 in subparagraph (C) are meeting the standards
7 adopted under this part and working together
8 to form an integrated network that meets the
9 needs of its users;

10 (E) the extent to which entities described
11 in subparagraph (C) are meeting the privacy
12 and security protections of part 2;

13 (F) whether the Federal Government and
14 State Governments are receiving information of
15 sufficient quality to meet their responsibilities
16 under this Act;

17 (G) any problems with respect to imple-
18 mentation of the network;

19 (H) the extent to which timetables under
20 this part for the adoption and implementation
21 of standards are being met; and

22 (I) any legislative recommendations related
23 to the health information network.

24 (2) AVAILABILITY TO THE PUBLIC.—Any infor-
25 mation in the report submitted to Congress under

1 paragraph (1) shall be made available to the public,
 2 unless such information may not be disclosed by law.

3 (h) DURATION.—Notwithstanding section 14(a) of
 4 the Federal Advisory Committee Act, the committee shall
 5 continue in existence until otherwise provided by law.

6 **PART 2—FAIR HEALTH INFORMATION**

7 **PRACTICES**

8 **SEC. 2140. DEFINITIONS.**

9 (a) DEFINITIONS RELATING TO PROTECTED
 10 HEALTH INFORMATION.—For purposes of this part:

11 (1) DISCLOSE.—The term “disclose”, when
 12 used with respect to protected health information
 13 that is held by a health information trustee, means
 14 to provide access to the information, but only if such
 15 access is provided by the trustee to a person other
 16 than—

17 (A) the trustee or an officer or employee of
 18 the trustee;

19 (B) an affiliated person of the trustee; or

20 (C) a protected individual who is a subject
 21 of the information.

22 (2) DISCLOSURE.—The term “disclosure”
 23 means the act or an instance of disclosing.

24 (3) PROTECTED HEALTH INFORMATION.—The
 25 term “protected health information” means any in-

formation, whether oral or recorded in any form or medium—

(A) that is created or received in a State by—

(i) a health care provider;

(ii) a health benefit plan sponsor;

(iii) a health oversight agency;

(iv) a health information service organization; or

(v) a public health authority;

(B) that relates in any way to the past, present, or future physical or mental health or condition or functional status of a protected individual, the provision of health care to a protected individual, or payment for the provision of health care to a protected individual; and

(C) that—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(4) PROTECTED INDIVIDUAL.—The term “protected individual” means an individual who, with respect to a date—

1 (A) is living on the date; or

2 (B) has died within the 2-year period end-
3 ing on the date.

4 (5) USE.—The term “use”, when used with re-
5 spect to protected health information that is held by
6 a health information trustee, means—

7 (A) to use, or provide access to, the infor-
8 mation in any manner that does not constitute
9 a disclosure; or

10 (B) any act or instance of using, or provid-
11 ing access, described in subparagraph (A).

12 (b) DEFINITIONS RELATING TO HEALTH INFORMA-
13 TION TRUSTEES.—For purposes of this part:

14 (1) CARRIER.—The term “carrier” means a li-
15 censed insurance company, a hospital or medical
16 service corporation (including an existing Blue Cross
17 or Blue Shield organization, within the meaning of
18 section 833(c)(2) of the Internal Revenue Code of
19 1986), a health maintenance organization, or other
20 entity licensed or certified by a State to provide
21 health insurance or health benefits.

22 (2) HEALTH BENEFIT PLAN.—The term
23 “health benefit plan” means—

24 (A) any contract of health insurance, in-
25 cluding any hospital or medical service policy or

1 certificate, hospital or medical service plan con-
2 tract, or health maintenance organization group
3 contract, that is provided by a carrier; and

4 (B) an employee welfare benefit plan or
5 other arrangement insofar as the plan or ar-
6 rangement provides health benefits and is fund-
7 ed in a manner other than through the pur-
8 chase of one or more policies or contracts de-
9 scribed in subparagraph (A).

10 (3) HEALTH BENEFIT PLAN SPONSOR.—The
11 term “health benefit plan sponsor” means a person
12 who, with respect to a specific item of protected
13 health information, receives, creates, uses, main-
14 tains, or discloses the information while acting in
15 whole or in part in the capacity of—

16 (A) a carrier providing a health benefit
17 plan;

18 (B) any other provider of a health benefit
19 plan, including any public entity that provides
20 payments for health care items and services
21 under a health benefit plan that are equivalent
22 to payments provided by a private person under
23 such a plan; or

24 (C) an officer or employee of a person de-
25 scribed in subparagraph (A) or (B).

1 (4) HEALTH CARE PROVIDER.—The term
2 “health care provider” means a person who, with re-
3 spect to a specific item of protected health informa-
4 tion, receives, creates, uses, maintains, or discloses
5 the information while acting in whole or in part in
6 the capacity of—

7 (A) a person who is licensed, certified, reg-
8 istered, or otherwise authorized by law to pro-
9 vide an item or service that constitutes health
10 care in the ordinary course of business or prac-
11 tice of a profession;

12 (B) a Federal or State program that di-
13 rectly provides items or services that constitute
14 health care to beneficiaries; or

15 (C) an officer or employee of a person de-
16 scribed in subparagraph (A) or (B).

17 (5) HEALTH INFORMATION SERVICE ORGANIZA-
18 TION.—The term “health information service organi-
19 zation” means a person who, with respect to a spe-
20 cific item of protected health information, receives,
21 creates, uses, maintains, or discloses the information
22 while acting in whole or in part in the capacity of—

23 (A) a person, other than an affiliated per-
24 son, who performs specific functions for which
25 the Secretary has authorized (by means of a

1 designation or certification) the person to re-
2 ceive access to health care data in electronic or
3 magnetic form that are regulated by this Act;
4 or

5 (B) an officer or employee of a person de-
6 scribed in subparagraph (A).

7 (6) HEALTH INFORMATION TRUSTEE.—The
8 term “health information trustee” means—

9 (A) a health care provider;

10 (B) a health information service organiza-
11 tion;

12 (C) a health oversight agency;

13 (D) a health benefit plan sponsor;

14 (E) a public health authority;

15 (F) a health researcher;

16 (G) a person who, with respect to a spe-
17 cific item of protected health information, is not
18 described in subparagraphs (A) through (F) but
19 receives the information—

20 (i) pursuant to—

21 (I) section 2157 (relating to
22 emergency circumstances);

23 (II) section 2158 (relating to ju-
24 dicial and administrative purposes);

1 (III) section 2159 (relating to
2 law enforcement); or

3 (IV) section 2160 (relating to
4 subpoenas, warrants, and search war-
5 rants); or

6 (ii) while acting in whole or in part in
7 the capacity of an officer or employee of a
8 person described in clause (i).

9 (7) HEALTH OVERSIGHT AGENCY.—The term
10 “health oversight agency” means a person who, with
11 respect to a specific item of protected health infor-
12 mation, receives, creates, uses, maintains, or dis-
13 closes the information while acting in whole or in
14 part in the capacity of—

15 (A) a person who performs or oversees the
16 performance of an assessment, evaluation, de-
17 termination, or investigation relating to the li-
18 censing, accreditation, or certification of health
19 care providers;

20 (B) a person who—

21 (i) performs or oversees the perform-
22 ance of an audit, assessment, evaluation,
23 determination, or investigation relating to
24 the effectiveness of, compliance with, or
25 applicability of, legal, fiscal, medical, or

1 scientific standards or aspects of perform-
2 ance related to the delivery of, or payment
3 for, health care; and

4 (ii) is a public agency, acting on be-
5 half of a public agency, acting pursuant to
6 a requirement of a public agency, or carry-
7 ing out activities under a State or Federal
8 statute regulating the assessment, evalua-
9 tion, determination, or investigation; or

10 (C) an officer or employee of a person de-
11 scribed in subparagraph (A) or (B).

12 (8) HEALTH RESEARCHER.—The term “health
13 researcher” means a person who, with respect to a
14 specific item of protected health information, re-
15 ceives the information—

16 (A) pursuant to section 2156 (relating to
17 health research); or

18 (B) while acting in whole or in part in the
19 capacity of an officer or employee of a person
20 described in subparagraph (A).

21 (9) PUBLIC HEALTH AUTHORITY.—The term
22 “public health authority” means a person who, with
23 respect to a specific item of protected health infor-
24 mation, receives, creates, uses, maintains, or dis-

1 closes the information while acting in whole or in
2 part in the capacity of—

3 (A) an authority of the United States, a
4 State, or a political subdivision of a State that
5 is responsible for public health matters;

6 (B) a person acting under the direction of
7 such an authority; or

8 (C) an officer or employee of a person de-
9 scribed in subparagraph (A) or (B).

10 (c) OTHER DEFINITIONS.—For purposes of this part:

11 (1) AFFILIATED PERSON.—The term “affiliated
12 person” means a person who—

13 (A) is not a health information trustee;

14 (B) is a contractor, subcontractor, associ-
15 ate, or subsidiary of a person who is a health
16 information trustee; and

17 (C) pursuant to an agreement or other re-
18 lationship with such trustee, receives, creates,
19 uses, maintains, or discloses protected health
20 information.

21 (2) APPROVED HEALTH RESEARCH PROJECT.—

22 The term “approved health research project” means
23 a biomedical, epidemiological, or health services re-
24 search or statistics project, or a research project on
25 behavioral and social factors affecting health, that

has been approved by a certified institutional review board.

(3) CERTIFIED INSTITUTIONAL REVIEW BOARD.—The term “certified institutional review board” means a board—

(A) established by an entity to review research involving protected health information and the rights of protected individuals conducted at or supported by the entity;

(B) established in accordance with regulations of the Secretary under section 2156(e)(1); and

(C) certified by the Secretary under section 2156(e)(2).

(4) HEALTH CARE.—The term “health care”—

(A) means—

(i) any preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

(I) with respect to the physical or mental condition, or functional status, of an individual; or

(II) affecting the structure or function of the human body or any

1 part of the human body, including
2 banking of blood, sperm, organs, or
3 any other tissue; or

4 (ii) any sale or dispensing of a drug,
5 device, equipment, or other item to an indi-
6 vidual, or for the use of an individual, pur-
7 suant to a prescription; but

8 (B) does not include any item or service
9 that is not furnished for the purpose of main-
10 taining or improving the health of an individual.

11 (5) LAW ENFORCEMENT INQUIRY.—The term
12 “law enforcement inquiry” means a lawful investiga-
13 tion or official proceeding inquiring into a violation
14 of, or failure to comply with, any criminal or civil
15 statute or any regulation, rule, or order issued pur-
16 suant to such a statute.

17 (6) PERSON.—The term “person” includes an
18 authority of the United States, a State, or a political
19 subdivision of a State.

20 **Subpart A—Duties of Health Information Trustees**

21 **SEC. 2141. INSPECTION OF PROTECTED HEALTH INFORMA-**
22 **TION.**

23 (a) IN GENERAL.—Except as provided in subsection
24 (b), a health information trustee described in subsection
25 (g)—

(1) shall permit a protected individual to inspect any protected health information about the individual that the trustee maintains, any accounting with respect to such information required under section 2144, and any copy of an authorization required under section 2152 that pertains to such information;

(2) shall provide the protected individual with a copy of the information upon request by the individual and subject to any conditions imposed by the trustee under subsection (d);

(3) shall permit a person who has been designated in writing by the protected individual to inspect the information on behalf of the individual or to accompany the individual during the inspection; and

(4) may offer to explain or interpret information that is inspected or copied under this subsection.

(b) EXCEPTIONS.—A health information trustee is not required by this section to permit inspection or copying of protected health information by a protected individual if any of the following conditions apply:

(1) MENTAL HEALTH TREATMENT NOTES.—

The information consists of psychiatric, psycho-

logical, or mental health treatment notes about the individual, the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the notes would cause sufficient harm to the protected individual so as to outweigh the desirability of permitting access, and the trustee does not disclose the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

(2) INFORMATION ABOUT OTHERS.—The information relates to an individual, other than the protected individual or a health care provider, and the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the information would cause sufficient harm to one or both of the individuals so as to outweigh the desirability of permitting access.

(3) ENDANGERMENT TO LIFE OR SAFETY.—Inspection or copying of the information could reasonably be expected to endanger the life or physical safety of an individual.

(4) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of an individual (other than a health care provider) who provided information under a promise of

1 confidentiality to a health care provider concerning
2 a protected individual who is a subject of the infor-
3 mation.

4 (5) ADMINISTRATIVE PURPOSES.—The informa-
5 tion—

6 (A) is used by the trustee solely for admin-
7 istrative purposes and not in the provision of
8 health care to a protected individual who is a
9 subject of the information; and

10 (B) is not disclosed by the trustee to any
11 person.

12 (6) DUPLICATIVE INFORMATION.—The informa-
13 tion duplicates information available for inspection
14 under subsection (a).

15 (7) INFORMATION COMPILED IN ANTICIPATION
16 OF LITIGATION.—The information is compiled prin-
17 cipally—

18 (A) in anticipation of a civil, criminal, or
19 administrative action or proceeding; or

20 (B) for use in such an action or proceed-
21 ing.

22 (c) INSPECTION AND COPYING OF SEGREGABLE POR-
23 TION.—A health information trustee shall permit inspec-
24 tion and copying under subsection (a) of any reasonably

1 segregable portion of a record after deletion of any portion
2 that is exempt under subsection (b).

3 (d) CONDITIONS.—A health information trustee
4 may—

5 (1) require a written request for the inspection
6 and copying of protected health information under
7 this section; and

8 (2) charge a reasonable cost-based fee for—

9 (A) permitting inspection of information
10 under this section; and

11 (B) providing a copy of protected health
12 information under this section.

13 (e) STATEMENT OF REASONS FOR DENIAL.—If a
14 health information trustee denies in whole or in part a
15 request for inspection or copying under this section, the
16 trustee shall provide the protected individual who made
17 the request with a written statement of the reasons for
18 the denial.

19 (f) DEADLINE.—A health information trustee shall
20 comply with or deny a request for inspection or copying
21 of protected health information under this section within
22 the 30-day period beginning on the date the trustee re-
23 ceives the request.

24 (g) APPLICABILITY.—This section applies to a health
25 information trustee who is—

- 1 (1) a health benefit plan sponsor;
- 2 (2) a health care provider;
- 3 (3) a health information service organization;
- 4 (4) a health oversight agency; or
- 5 (5) a public health authority.

6 **SEC. 2142. AMENDMENT OF PROTECTED HEALTH INFORMA-**
7 **TION.**

8 (a) IN GENERAL.—A health information trustee de-
9 scribed in subsection (f) shall, within the 45-day period
10 beginning on the date the trustee receives from a protected
11 individual about whom the trustee maintains protected
12 health information a written request that the trustee cor-
13 rect or amend the information, complete the duties de-
14 scribed in one of the following paragraphs:

15 (1) CORRECTION OR AMENDMENT AND NOTIFI-
16 CATION.—The trustee shall—

17 (A) make the correction or amendment re-
18 quested;

19 (B) inform the protected individual of the
20 amendment or correction that has been made;

21 (C) make reasonable efforts to inform any
22 person who is identified by the protected indi-
23 vidual, who is not an employee of the trustee,
24 and to whom the uncorrected or unamended
25 portion of the information was previously dis-

1 closed of the correction or amendment that has
2 been made; and

3 (D) at the request of the individual, make
4 reasonable efforts to inform any known source
5 of the uncorrected or unamended portion of the
6 information about the correction or amendment
7 that has been made.

8 (2) REASONS FOR REFUSAL AND REVIEW PRO-
9 CEDURES.—The trustee shall inform the protected
10 individual of—

11 (A) the reasons for the refusal of the trust-
12 ee to make the correction or amendment;

13 (B) any procedures for further review of
14 the refusal; and

15 (C) the individual's right to file with the
16 trustee a concise statement setting forth the re-
17 quested correction or amendment and the indi-
18 vidual's reasons for disagreeing with the refusal
19 of the trustee.

20 (b) STANDARDS FOR CORRECTION OR AMEND-
21 MENT.—A trustee shall correct or amend protected health
22 information in accordance with a request made under sub-
23 section (a) if the trustee determines that the information
24 is not accurate, relevant, timely, or complete for the pur-

1 poses for which the information may be used or disclosed
2 by the trustee.

3 (c) STATEMENT OF DISAGREEMENT.—After a pro-
4 tected individual has filed a statement of disagreement
5 under subsection (a)(2)(C), the trustee, in any subsequent
6 disclosure of the disputed portion of the information, shall
7 include a copy of the individual's statement and may in-
8 clude a concise statement of the trustee's reasons for not
9 making the requested correction or amendment.

10 (d) CONSTRUCTION.—This section may not be con-
11 strued to require a health information trustee to conduct
12 a hearing or proceeding concerning a request for a correc-
13 tion or amendment to protected health information the
14 trustee maintains.

15 (e) CORRECTION.—For purposes of subsection (a), a
16 correction is deemed to have been made to protected
17 health information when—

18 (1) information that is not timely, accurate, rel-
19 evant, or complete is clearly marked as incorrect; or

20 (2) supplementary correct information is made
21 part of the information and adequately cross-ref-
22 erenced.

23 (f) APPLICABILITY.—This section applies to a health
24 information trustee who is—

25 (1) a health benefit plan sponsor;

- (2) a health care provider;
- (3) a health information service organization;
- (4) a health oversight agency; or
- (5) a public health authority.

SEC. 2143. NOTICE OF INFORMATION PRACTICES.

(a) PREPARATION OF NOTICE.—A health information trustee described in subsection (d) shall prepare a written notice of information practices describing the following:

(1) The rights under this part of a protected individual who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclosures of protected health information and for revoking such authorizations.

(2) The procedures established by the trustee for the exercise of such rights.

(3) The uses and disclosures of protected health information that are authorized under this part.

(b) DISSEMINATION OF NOTICE.—A health information trustee—

(1) shall, upon request, provide any person with a copy of the trustee's notice of information practices (described in subsection (a)); and

1 (2) shall make reasonable efforts to inform per-
 2 sons in a clear and conspicuous manner of the exist-
 3 ence and availability of such notice.

4 (c) MODEL NOTICES.—Not later than July 1, 1996,
 5 the Secretary, after notice and opportunity for public com-
 6 ment, shall develop and disseminate model notices of infor-
 7 mation practices for use by health information trustees
 8 under this section.

9 (d) APPLICABILITY.—This section applies to a health
 10 information trustee who is—

11 (1) a health benefit plan sponsor;

12 (2) a health care provider;

13 (3) a health information service organization; or

14 (4) a health oversight agency.

15 **SEC. 2144. ACCOUNTING FOR DISCLOSURES.**

16 (a) IN GENERAL.—Except as provided in subsection
 17 (b) and section 2154, each health information trustee shall
 18 create and maintain, with respect to any protected health
 19 information the trustee discloses, a record of—

20 (1) the date and purpose of the disclosure;

21 (2) the name of the person to whom the disclo-
 22 sure was made;

23 (3) the address of the person to whom the dis-
 24 closure was made or the location to which the disclo-
 25 sure was made; and

1 (4) where practicable, a description of the infor-
2 mation disclosed.

3 (b) REGULATIONS.—Not later than July 1, 1996, the
4 Secretary shall promulgate regulations that exempt a
5 health information trustee from maintaining a record
6 under subsection (a) with respect to protected health in-
7 formation disclosed by the trustee for purposes of peer re-
8 view, licensing, certification, accreditation, and similar ac-
9 tivities.

10 **SEC. 2145. SECURITY.**

11 (a) IN GENERAL.—Each health information trustee
12 who receives or creates protected health information that
13 is subject to this part shall maintain reasonable and ap-
14 propriate administrative, technical, and physical safe-
15 guards—

16 (1) to ensure the integrity and confidentiality of
17 the information;

18 (2) to protect against any reasonably antici-
19 pated—

20 (A) threats or hazards to the security or
21 integrity of the information; and

22 (B) unauthorized uses or disclosures of the
23 information; and

1 (3) otherwise ensure compliance with this part
2 by the trustee and the officers and employees of the
3 trustee.

(b) GUIDELINES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate guidelines for the implementation of this section. The guidelines shall take into account—

9 (1) the technical capabilities of record systems
10 used to maintain protected health information;

11 (2) the costs of security measures;

12 (3) the need for training persons who have ac-
13 cess to protected health information; and

14 (4) the value of audit trails in computerized
15 record systems.

16 Subpart B—Use and Disclosure of Protected Health
17 Information

18 SEC. 2151. GENERAL LIMITATIONS ON USE AND DISCLO-
19 SURE.

(a) USE.—Except as otherwise provided under this part, a health information trustee may use protected health information only for a purpose—

23 (1) that is compatible with and directly related
24 to the purpose for which the information—

25 (A) was collected; or

1 (B) was received by the trustee; or

2 (2) for which the trustee is authorized to dis-
3 close the information under this part.

4 (b) DISCLOSURE.—A health information trustee may
5 disclose protected health information only as authorized
6 under this part.

7 (c) SCOPE OF USES AND DISCLOSURES.—

8 (1) IN GENERAL.—A use or disclosure of pro-
9 tected health information by a health information
10 trustee shall be limited, when practicable, to the
11 minimum amount of information necessary to ac-
12 complish the purpose for which the information is
13 used or disclosed.

14 (2) GUIDELINES.—Not later than July 1, 1996,
15 the Secretary, after notice and opportunity for pub-
16 lic comment, shall issue guidelines to implement
17 paragraph (1), which shall take into account the
18 technical capabilities of the record systems used to
19 maintain protected health information and the costs
20 of limiting use and disclosure.

21 (d) IDENTIFICATION OF DISCLOSED INFORMATION
22 AS PROTECTED INFORMATION.—Except with respect to
23 protected health information that is disclosed under sec-
24 tion 2154 (relating to next of kin and directory informa-
25 tion), a health information trustee may disclose protected

1 health information only if the recipient has been notified
2 that the information is protected health information that
3 is subject to this part.

4 (e) AGREEMENT TO LIMIT USE OR DISCLOSURE.—

5 A health information trustee who receives protected health
6 information from any person pursuant to a written agree-
7 ment to restrict use or disclosure of the information to
8 a greater extent than otherwise would be required under
9 this part shall comply with the terms of the agreement,
10 except where use or disclosure of the information in viola-
11 tion of the agreement is required by law. A trustee who
12 fails to comply with the preceding sentence shall be subject
13 to section 2191 (relating to civil actions) with respect to
14 such failure.

15 (f) NO GENERAL REQUIREMENT TO DISCLOSE.—

16 Nothing in this part shall be construed to require a health
17 information trustee to disclose protected health informa-
18 tion not otherwise required to be disclosed by law.

19 **SEC. 2152. AUTHORIZATIONS FOR DISCLOSURE OF PRO-**
20 **TECTED HEALTH INFORMATION.**

21 (a) WRITTEN AUTHORIZATIONS.—A health informa-
22 tion trustee, other than a health information service orga-
23 nization, may disclose protected health information pursu-
24 ant to an authorization executed by the protected individ-

1 ual who is the subject of the information, if each of the
2 following requirements is satisfied:

3 (1) WRITING.—The authorization is in writing,
4 signed by the individual, and dated on the date of
5 such signature.

6 (2) SEPARATE FORM.—The authorization is not
7 on a form used to authorize or facilitate the provi-
8 sion of, or payment for, health care.

9 (3) TRUSTEE DESCRIBED.—The trustee is spe-
10 cifically named or generically described in the au-
11 thorization as authorized to disclose such informa-
12 tion.

13 (4) RECIPIENT DESCRIBED.—The person to
14 whom the information is to be disclosed is specifi-
15 cally named or generically described in the author-
16 ization as a person to whom such information may
17 be disclosed.

18 (5) STATEMENT OF INTENDED USES AND DIS-
19 CLOSURES RECEIVED.—The authorization contains
20 an acknowledgment that the individual has received
21 a statement described in subsection (b) from such
22 person.

23 (6) INFORMATION DESCRIBED.—The informa-
24 tion to be disclosed is described in the authorization.

1 (7) AUTHORIZATION TIMELY RECEIVED.—The
2 authorization is received by the trustee during a pe-
3 riod described in subsection (c)(1).

4 (8) DISCLOSURE TIMELY MADE.—The disclo-
5 sure occurs during a period described in subsection
6 (c)(2).

7 (b) STATEMENT OF INTENDED USES AND DISCLO-
8 SURES.—

9 (1) IN GENERAL.—A person who wishes to re-
10 ceive from a health information trustee protected
11 health information about a protected individual pur-
12 suant to an authorization executed by the individual
13 shall supply the individual, in writing and on a form
14 that is distinct from the authorization, with a state-
15 ment of the uses for which the person intends the
16 information and the disclosures the person intends
17 to make of the information. Such statement shall be
18 supplied before the authorization is executed.

19 (2) ENFORCEMENT.—If the person uses or dis-
20 closes the information in a manner that is inconsis-
21 tent with such statement, the person shall be subject
22 to section 2191 (relating to civil actions) with re-
23 spect to such failure, except where such use or dis-
24 closure is required by law.

1 (3) MODEL STATEMENTS.—Not later than July
 2 1, 1996, the Secretary, after notice and opportunity
 3 for public comment, shall develop and disseminate
 4 model statements of intended uses and disclosures of
 5 the type described in paragraph (1).

6 (c) TIME LIMITATIONS ON AUTHORIZATIONS.—

7 (1) RECEIPT BY TRUSTEE.—For purposes of
 8 subsection (a)(7), an authorization is timely received
 9 if it is received by the trustee during—

10 (A) the 1-year period beginning on the
 11 date that the authorization is signed under sub-
 12 section (a)(1), if the authorization permits the
 13 disclosure of protected health information to—

14 (i) a health benefit plan sponsor;
 15 (ii) a health care provider;
 16 (iii) a health oversight agency;
 17 (iv) a public health authority;
 18 (v) a health researcher; or
 19 (vi) a person who provides counseling
 20 or social services to individuals; or

21 (B) the 30-day period beginning on the
 22 date that the authorization is signed under sub-
 23 section (a)(1), if the authorization permits the
 24 disclosure of protected health information to a

1 person other than a person described in sub-
2 paragraph (A).

3 (2) DISCLOSURE BY TRUSTEE.—For purposes
4 of subsection (a)(8), a disclosure is timely made if
5 it occurs before—

6 (A) the date or event (if any) specified in
7 the authorization upon which the authorization
8 expires; and

9 (B) the expiration of the 6-month period
10 beginning on the date the trustee receives the
11 authorization.

12 (d) REVOCATION OR AMENDMENT OF AUTHORIZA-
13 TION.—

14 (1) IN GENERAL.—A protected individual in
15 writing may revoke or amend an authorization de-
16 scribed in subsection (a), in whole or in part, at any
17 time, except insofar as—

18 (A) disclosure of protected health informa-
19 tion has been authorized to permit validation of
20 expenditures based on health condition by a
21 government authority; or

22 (B) action has been taken in reliance on
23 the authorization.

24 (2) NOTICE OF REVOCATION.—A health infor-
25 mation trustee who discloses protected health infor-

1 mation in reliance on an authorization that has been
2 revoked shall not be subject to any liability or pen-
3 alty under this part if—

4 (A) the reliance was in good faith;

5 (B) the trustee had no notice of the rev-
6 ocation; and

7 (C) the disclosure was otherwise in accord-
8 ance with the requirements of this section.

9 (e) ADDITIONAL REQUIREMENTS OF TRUSTEE.—A
10 health information trustee may impose requirements for
11 an authorization that are in addition to the requirements
12 in this section.

13 (f) COPY.—A health information trustee who dis-
14 closes protected health information pursuant to an author-
15 ization under this section shall maintain a copy of the au-
16 thorization.

17 (g) CONSTRUCTION.—This section may not be con-
18 strued—

19 (1) to require a health information trustee to
20 disclose protected health information; or

21 (2) to limit the right of a health information
22 trustee to charge a fee for the disclosure or repro-
23 duction of protected health information.

24 (h) SUBPOENAS, WARRANTS, AND SEARCH WAR-
25 RANTS.—If a health information trustee discloses pro-

1 tected health information pursuant to an authorization in
2 order to comply with an administrative subpoena or war-
3 rant or a judicial subpoena or search warrant, the author-
4 ization—

5 (1) shall specifically authorize the disclosure for
6 the purpose of permitting the trustee to comply with
7 the subpoena, warrant, or search warrant; and

8 (2) shall otherwise meet the requirements in
9 this section.

10 **SEC. 2153. TREATMENT, PAYMENT, AND OVERSIGHT.**

11 (a) DISCLOSURES BY PLANS, PROVIDERS, AND
12 OVERSIGHT AGENCIES.—A health information trustee de-
13 scribed in subsection (d) may disclose protected health in-
14 formation to a health benefit plan sponsor, health care
15 provider, or health oversight agency if the disclosure is—

16 (1) for the purpose of providing health care and
17 a protected individual who is a subject of the infor-
18 mation has not previously objected to the disclosure
19 in writing;

20 (2) for the purpose of providing for the pay-
21 ment for health care furnished to an individual; or

22 (3) for use by a health oversight agency for a
23 purpose that is described in subparagraph (A) or
24 (B)(i) of section 2140(b)(7).

1 (b) DISCLOSURES BY CERTAIN OTHER TRUSTEES.—

2 A health information trustee may disclose protected health
3 information to a health care provider if—

4 (1) the disclosure is for the purpose described
5 in subsection (a)(1); and

6 (2) the trustee—

7 (A) is a public health authority;

8 (B) received protected health information
9 pursuant to section 2157 (relating to emergency
10 circumstances); or

11 (C) is an officer or employee of a trustee
12 described in subsection (B).

13 (c) USE IN ACTION AGAINST INDIVIDUAL.—A person
14 who receives protected health information about a pro-
15 tected individual through a disclosure under this section
16 may not use or disclose the information in any administra-
17 tive, civil, or criminal action or investigation directed
18 against the individual, except an action or investigation
19 arising out of and related to receipt of health care or pay-
20 ment for health care.

21 (d) APPLICABILITY.—A health information trustee
22 referred to in subsection (a) is any of the following:

23 (1) A health benefit plan sponsor.

24 (2) A health care provider.

25 (3) A health oversight agency.

1 (4) A health information service organization.

2 **SEC. 2154. NEXT OF KIN AND DIRECTORY INFORMATION.**

3 (a) NEXT OF KIN.—A health information trustee who
4 is a health care provider, who received protected health
5 information pursuant to section 2157 (relating to emer-
6 gency circumstances), or who is an officer or employee of
7 such a recipient may orally disclose protected health infor-
8 mation about a protected individual to the next of kin of
9 the individual (as defined under State law), or to a person
10 with whom the individual has a close personal relationship,
11 if—

12 (1) the trustee has no reason to believe that the
13 individual would consider the information especially
14 sensitive;

15 (2) the individual has not previously objected to
16 the disclosure;

17 (3) the disclosure is consistent with good medi-
18 cal or other professional practice; and

19 (4) the information disclosed is limited to infor-
20 mation about health care that is being provided to
21 the individual at or about the time of the disclosure.

22 (b) DIRECTORY INFORMATION.—

23 (1) IN GENERAL.—A health information trustee
24 who is a health care provider, who received protected
25 health information pursuant to section 2157 (relat-

ing to emergency circumstances), or who is an officer or employee of such a recipient may disclose to any person the information described in paragraph (2) if—

(A) a protected individual who is a subject of the information has not objected in writing to the disclosure;

(B) the disclosure is otherwise consistent with good medical and other professional practice; and

(C) the information does not reveal specific information about the physical or mental condition or functional status of a protected individual or about the health care provided to a protected individual.

(2) INFORMATION DESCRIBED.—The information referred to in paragraph (1) is the following:

(A) The name of an individual receiving health care from a health care provider on a premises controlled by the provider.

(B) The location of the individual on such premises.

(C) The general health status of the individual, described in terms of critical, poor, fair,

1 stable, satisfactory, or terms denoting similar
2 conditions.

3 (c) NO ACCOUNTING REQUIRED.—A health informa-
4 tion trustee who discloses protected health information
5 under this section is not required to maintain an account-
6 ing of the disclosure under section 2144.

7 (d) RECIPIENTS.—A person to whom protected
8 health information is disclosed under this section shall not,
9 by reason of such disclosure, be subject to any require-
10 ment under this part.

11 **SEC. 2155. PUBLIC HEALTH.**

12 (a) IN GENERAL.—A health information trustee who
13 is a health care provider or a public health authority may
14 disclose protected health information to—

15 (1) a public health authority for use in legally
16 authorized—

17 (A) disease or injury reporting;

18 (B) public health surveillance; or

19 (C) public health investigation or interven-
20 tion; or

21 (2) an individual who is authorized by law to
22 receive the information in a public health interven-
23 tion.

24 (b) USE IN ACTION AGAINST INDIVIDUAL.—A public
25 health authority who receives protected health information

1 about a protected individual through a disclosure under
2 this section may not use or disclose the information in any
3 administrative, civil, or criminal action or investigation di-
4 rected against the individual, except where the use or dis-
5 closure is authorized by law for protection of the public
6 health.

7 (c) INDIVIDUAL RECIPIENTS.—An individual to
8 whom protected health information is disclosed under sub-
9 section (a)(2) shall not, by reason of such disclosure, be
10 subject to any requirement under this part.

11 **SEC. 2156. HEALTH RESEARCH.**

12 (a) IN GENERAL.—A health information trustee de-
13 scribed in subsection (d) may disclose protected health in-
14 formation to a person if—

15 (1) the person is conducting an approved health
16 research project;

17 (2) the information is to be used in the project;
18 and

19 (3) the project has been determined by a cer-
20 tified institutional review board to be—

21 (A) of sufficient importance so as to out-
22 weigh the intrusion into the privacy of the pro-
23 tected individual who is the subject of the infor-
24 mation that would result from the disclosure;
25 and

1 (B) impracticable to conduct without the
2 information.

3 (b) DISCLOSURES BY HEALTH INFORMATION SERV-
4 ICE ORGANIZATIONS.—A health information service orga-
5 nization may disclose protected health information under
6 subsection (a) only if the certified institutional review
7 board referred to in subsection (a)(3) has been certified
8 as being qualified to make determinations under such sub-
9 section with respect to disclosures by such organizations.

10 (c) LIMITATIONS ON USE AND DISCLOSURE; OBLIGA-
11 TIONS OF RECIPIENT.—A health researcher who receives
12 protected health information about a protected individual
13 pursuant to subsection (a)—

14 (1) may use the information solely for purposes
15 of an approved health research project;

16 (2) may not use or disclose the information in
17 any administrative, civil, or criminal action or inves-
18 tigation directed against the individual; and

19 (3) shall remove or destroy, at the earliest op-
20 portunity consistent with the purposes of the ap-
21 proved health research project in connection with
22 which the disclosure was made, information that
23 would enable an individual to be identified, unless a
24 certified institutional review board has determined
25 that there is a health or research justification for re-

1 tention of such identifiers and there is an adequate
2 plan to protect the identifiers from use and disclo-
3 sure that is inconsistent with this part.

4 (d) APPLICABILITY.—A health information trustee
5 referred to in subsection (a) is any health information
6 trustee other than a person who, with respect to the spe-
7 cific protected health information to be disclosed under
8 such subsection, received the information—

9 (1) pursuant to—

10 (A) section 2158 (relating to judicial and
11 administrative purposes);

12 (B) paragraph (1), (2), or (3) of section
13 2159(a) (relating to law enforcement); or

14 (C) section 2160 (relating to subpoenas,
15 warrants, and search warrants); or

16 (2) while acting in whole or in part in the ca-
17 pacity of an officer or employee of a person de-
18 scribed in paragraph (1).

19 (e) REQUIREMENTS FOR INSTITUTIONAL REVIEW
20 BOARDS.—

21 (1) REGULATIONS.—Not later than July 1,
22 1996, the Secretary, after opportunity for notice and
23 comment, shall promulgate regulations establishing
24 requirements for certified institutional review boards
25 under this part. The regulations shall be based on

1 regulations promulgated under section 491(a) of the
2 Public Health Service Act and shall ensure that cer-
3 tified institutional review boards are qualified to as-
4 sess and protect the confidentiality of research sub-
5 jects. The regulations shall include specific require-
6 ments for certified institutional review boards that
7 make determinations under subsection (a)(3) with
8 respect to disclosures by health information service
9 organizations.

10 (2) CERTIFICATION.—The Secretary shall cer-
11 tify that an institutional review board satisfies the
12 requirements of the regulations promulgated under
13 paragraph (1).

14 **SEC. 2157. EMERGENCY CIRCUMSTANCES.**

15 (a) IN GENERAL.—A health information trustee may
16 disclose protected health information if the trustee be-
17 lieves, on reasonable grounds, that the disclosure is nec-
18 essary to prevent or lessen a serious and imminent threat
19 to the health or safety of an individual.

20 (b) USE IN ACTION AGAINST INDIVIDUAL.—A person
21 who receives protected health information about a pro-
22 tected individual through a disclosure under this section
23 may not use or disclose the information in any administra-
24 tive, civil, or criminal action or investigation directed
25 against the individual, except an action or investigation

1 arising out of and related to receipt of health care or pay-
2 ment for health care.

3 **SEC. 2158. JUDICIAL AND ADMINISTRATIVE PURPOSES.**

4 (a) IN GENERAL.—A health information trustee de-
5 scribed in subsection (d) may disclose protected health in-
6 formation—

7 (1) pursuant to the Federal Rules of Civil Pro-
8 cedure, the Federal Rules of Criminal Procedure, or
9 comparable rules of other courts or administrative
10 agencies in connection with litigation or proceedings
11 to which a protected individual who is a subject of
12 the information is a party and in which the individ-
13 ual has placed the individual's physical or mental
14 condition or functional status in issue;

15 (2) if directed by a court in connection with a
16 court-ordered examination of an individual; or

17 (3) to assist in the identification of a dead indi-
18 vidual.

19 (b) WRITTEN STATEMENT.—A person seeking pro-
20 tected health information about a protected individual held
21 by health information trustee under—

22 (1) subsection (a)(1)—

23 (A) shall notify the protected individual or
24 the attorney of the protected individual of the
25 request for the information;

(B) shall provide the trustee with a signed document attesting—

(i) that the protected individual is a party to the litigation or proceedings for which the information is sought;

(ii) that the individual has placed the individual's physical or mental condition or functional status in issue; and

(iii) the date on which the protected individual or the attorney of the protected individual was notified under subparagraph (A); and

(C) shall not accept any requested protected health information from the trustee until the termination of the 10-day period beginning on the date notice was given under subparagraph (A); or

(2) subsection (a)(3) shall provide the trustee with a written statement that the information is sought to assist in the identification of a dead individual.

(c) USE AND DISCLOSURE.—A person to whom protected health information is disclosed under this section may use and disclose the information only to accomplish the purpose for which the disclosure was made.

1 (d) APPLICABILITY.—A health information trustee
2 referred to in subsection (a) is any of the following:

3 (1) A health benefit plan sponsor.

4 (2) A health care provider.

5 (3) A health oversight agency.

6 (4) A person who, with respect to the specific
7 protected health information to be disclosed under
8 such subsection, received the information—

9 (A) pursuant to—

10 (i) section 2157 (relating to emer-
11 gency circumstances); or

12 (ii) section 2160 (relating to subpoe-
13 nas, warrants, and search warrants); or

14 (B) while acting in whole or in part in the
15 capacity of an officer or employee of a person
16 described in subparagraph (A).

17 **SEC. 2159. LAW ENFORCEMENT.**

18 (a) IN GENERAL.—A health information trustee,
19 other than a health information service organization, may
20 disclose protected health information to a law enforcement
21 agency, other than a health oversight agency—

22 (1) if the information is disclosed for use in an
23 investigation or prosecution of a health information
24 trustee;

(2) in connection with criminal activity committed against the trustee or an affiliated person of the trustee or on premises controlled by the trustee; or

(3) if the information is needed to determine whether a crime has been committed and the nature of any crime that may have been committed (other than a crime that may have been committed by the protected individual who is the subject of the information).

(b) ADDITIONAL AUTHORITY OF CERTAIN TRUSTEES.—A health information trustee who is not a health information service organization, a public health authority, or a health researcher may disclose protected health information to a law enforcement agency (other than a health oversight agency)—

(1) to assist in the identification or location of a victim, fugitive, or witness in a law enforcement inquiry;

(2) pursuant to a law requiring the reporting of specific health care information to law enforcement authorities; or

(3) if the information is specific health information described in paragraph (2) and the trustee is operated by a Federal agency.

1 (c) CERTIFICATION.—Where a law enforcement agen-
2 cy requests a health information trustee to disclose pro-
3 tected health information under subsection (a) or (b)(1),
4 the agency shall provide the trustee with a written certifi-
5 cation that—

6 (1) is signed by a supervisory official of a rank
7 designated by the head of the agency;

8 (2) specifies the information requested; and

9 (3) states that the information is needed for a
10 lawful purpose under this section.

11 (d) RESTRICTIONS ON DISCLOSURE AND USE.—A
12 person who receives protected health information about a
13 protected individual through a disclosure under this sec-
14 tion may not use or disclose the information—

15 (1) in any administrative, civil, or criminal ac-
16 tion or investigation directed against the individual,
17 except an action or investigation arising out of and
18 directly related to the action or investigation for
19 which the information was obtained; and

20 (2) otherwise unless the use or disclosure is
21 necessary to fulfill the purpose for which the infor-
22 mation was obtained and is not prohibited by any
23 other provision of law.

1 **SEC. 2160. SUBPOENAS, WARRANTS, AND SEARCH WAR-**
2 **RANTS.**

3 (a) **IN GENERAL.**—A health information trustee de-
4 scribed in subsection (g) may disclose protected health in-
5 formation if the disclosure is pursuant to any of the fol-
6 lowing:

7 (1) A subpoena issued under the authority of a
8 grand jury and the trustee is provided a written cer-
9 tification by the grand jury that the grand jury has
10 complied with the applicable access provisions of sec-
11 tion 2171.

12 (2) An administrative subpoena or warrant or
13 a judicial subpoena or search warrant and the trust-
14 ee is provided a written certification by the person
15 seeking the information that the person has com-
16 plied with the applicable access provisions of section
17 2171 or 2173(a).

18 (3) An administrative subpoena or warrant or
19 a judicial subpoena or search warrant and the dis-
20 closure otherwise meets the conditions of one of sec-
21 tions 2153 through 2159.

22 (b) **AUTHORITY OF ALL TRUSTEES.**—Any health in-
23 formation trustee may disclose protected health informa-
24 tion if the disclosure is pursuant to subsection (a)(3).

1 (c) RESTRICTIONS ON USE AND DISCLOSURE.—Pro-
2 tected health information about a protected individual that
3 is disclosed by a health information trustee pursuant to—

4 (1) subsection (a)(2) may not be otherwise used
5 or disclosed by the recipient unless the use or disclo-
6 sure is necessary to fulfill the purpose for which the
7 information was obtained; and

8 (2) subsection (a)(3) may not be used or dis-
9 closed by the recipient unless the recipient complies
10 with the conditions and restrictions on use and dis-
11 closure with which the recipient would have been re-
12 quired to comply if the disclosure by the trustee had
13 been made under the section referred to in sub-
14 section (a)(3) the conditions of which were met by
15 the disclosure.

16 (d) RESTRICTIONS ON GRAND JURIES.—Protected
17 health information that is disclosed by a health informa-
18 tion trustee under subsection (a)(1)—

19 (1) shall be returnable on a date when the
20 grand jury is in session and actually presented to
21 the grand jury;

22 (2) shall be used only for the purpose of consid-
23 ering whether to issue an indictment or report by
24 that grand jury, or for the purpose of prosecuting a
25 crime for which that indictment or report is issued,

1 or for a purpose authorized by rule 6(e) of the Fed-
2 eral Rules of Criminal Procedure or a comparable
3 State rule;

4 (3) shall be destroyed or returned to the trustee
5 if not used for one of the purposes specified in para-
6 graph (2); and

7 (4) shall not be maintained, or a description of
8 the contents of such information shall not be main-
9 tained, by any government authority other than in
10 the sealed records of the grand jury, unless such in-
11 formation has been used in the prosecution of a
12 crime for which the grand jury issued an indictment
13 or presentment or for a purpose authorized by rule
14 6(e) of the Federal Rules of Criminal Procedure or
15 a comparable State rule.

16 (e) USE IN ACTION AGAINST INDIVIDUAL.—A person
17 who receives protected health information about a pro-
18 tected individual through a disclosure under this section
19 may not use or disclose the information in any administra-
20 tive, civil, or criminal action or investigation directed
21 against the individual, except an action or investigation
22 arising out of and directly related to the inquiry for which
23 the information was obtained;

24 (f) CONSTRUCTION.—Nothing in this section shall be
25 construed as authority for a health information trustee to

1 refuse to comply with a valid administrative subpoena or
2 warrant or a valid judicial subpoena or search warrant
3 that meets the requirements of this part.

4 (g) APPLICABILITY.—A health information trustee
5 referred to in subsection (a) is any trustee other than the
6 following:

7 (1) A health information service organization.

8 (2) A public health authority.

9 (3) A health researcher.

10 **SEC. 2161. HEALTH INFORMATION SERVICE ORGANIZA-**
11 **TIONS.**

12 A health information trustee may disclose protected
13 health information to a health information service organi-
14 zation for the purpose of permitting the organization to
15 perform a function for which the Secretary has authorized
16 (by means of a designation or certification) the organiza-
17 tion to receive access to health care data in electronic or
18 magnetic form that are regulated by this Act.

19 **Subpart C—Access Procedures and Challenge Rights**

20 **SEC. 2171. ACCESS PROCEDURES FOR LAW ENFORCEMENT**
21 **SUBPOENAS, WARRANTS, AND SEARCH WAR-**
22 **RANTS.**

23 (a) PROBABLE CAUSE REQUIREMENT.—A govern-
24 ment authority may not obtain protected health informa-
25 tion about a protected individual from a health informa-

1 tion trustee under paragraph (1) or (2) of section 2160(a)
2 for use in a law enforcement inquiry unless there is prob-
3 able cause to believe that the information is relevant to
4 a legitimate law enforcement inquiry being conducted by
5 the government authority.

6 (b) WARRANTS AND SEARCH WARRANTS.—A govern-
7 ment authority that obtains protected health information
8 about a protected individual from a health information
9 trustee under circumstances described in subsection (a)
10 and pursuant to a warrant or search warrant shall, not
11 later than 30 days after the date the warrant was served
12 on the trustee, serve the individual with, or mail to the
13 last known address of the individual, a copy of the war-
14 rant.

15 (c) SUBPOENAS.—Except as provided in subsection
16 (d), a government authority may not obtain protected
17 health information about a protected individual from a
18 health information trustee under circumstances described
19 in subsection (a) and pursuant to a subpoena unless a
20 copy of the subpoena has been served by hand delivery
21 upon the individual, or mailed to the last known address
22 of the individual, on or before the date on which the sub-
23 poena was served on the trustee, together with a notice
24 (published by the Secretary under section 2175(1)) of the

1 individual's right to challenge the subpoena in accordance
2 with section 2172, and—

3 (1) 30 days have passed from the date of serv-
4 ice, or 30 days have passed from the date of mailing,
5 and within such time period the individual has not
6 initiated a challenge in accordance with section
7 2172; or

8 (2) disclosure is ordered by a court under sec-
9 tion 2172.

10 (d) APPLICATION FOR DELAY.—

11 (1) IN GENERAL.—A government authority may
12 apply to an appropriate court to delay (for an initial
13 period of not longer than 90 days) serving a copy of
14 a subpoena and a notice otherwise required under
15 subsection (c) with respect to a law enforcement in-
16 quiry. The government authority may apply to the
17 court for extensions of the delay.

18 (2) REASONS FOR DELAY.—An application for
19 a delay, or extension of a delay, under this sub-
20 section shall state, with reasonable specificity, the
21 reasons why the delay or extension is being sought.

22 (3) EX PARTE ORDER.—The court shall enter
23 an ex parte order delaying, or extending the delay
24 of, the notice and an order prohibiting the trustee
25 from revealing the request for, or the disclosure of,

1 the protected health information being sought if the
2 court finds that—

3 (A) the inquiry being conducted is within
4 the lawful jurisdiction of the government au-
5 thority seeking the protected health informa-
6 tion;

7 (B) there is probable cause to believe that
8 the protected health information being sought is
9 relevant to a legitimate law enforcement inquiry
10 being conducted by the government authority;

11 (C) the government authority's need for
12 the information outweighs the privacy interest
13 of the protected individual who is the subject of
14 the information; and

15 (D) there are reasonable grounds to believe
16 that receipt of a notice by the individual will re-
17 sult in—

18 (i) endangering the life or physical
19 safety of any individual;

20 (ii) flight from prosecution;

21 (iii) destruction of or tampering with
22 evidence or the information being sought;

23 or

24 (iv) intimidation of potential wit-
25 nesses.

1 (4) SERVICE OF APPLICATION ON INDIVID-
2 UAL.—Upon the expiration of a period of delay of
3 notice under this subsection, the government author-
4 ity shall serve upon the individual, with the service
5 of the subpoena and the notice, a copy of any appli-
6 cations filed and approved under this subsection.

7 **SEC. 2172. CHALLENGE PROCEDURES FOR LAW ENFORCE-**
8 **MENT SUBPOENAS.**

9 (a) MOTION TO QUASH SUBPOENA.—Within 30 days
10 of the date of service, or 30 days of the date of mailing,
11 of a subpoena of a government authority seeking protected
12 health information about a protected individual from a
13 health information trustee under paragraph (1) or (2) of
14 section 2160(a) (except a subpoena to which section 2173
15 applies), the individual may file (without filing fee) a mo-
16 tion to quash the subpoena—

17 (1) in the case of a State judicial subpoena, in
18 the court which issued the subpoena;

19 (2) in the case of a subpoena issued under the
20 authority of a State that is not a State judicial sub-
21 poena, in a court of competent jurisdiction;

22 (3) in the case of a subpoena issued under the
23 authority of a Federal court, in any court of the
24 United States of competent jurisdiction; or

1 (4) in the case of any other subpoena issued
2 under the authority of the United States, in—

3 (A) the United States district court for the
4 district in which the individual resides or in
5 which the subpoena was issued; or

6 (B) another United States district court of
7 competent jurisdiction.

8 (b) COPY.—A copy of the motion shall be served by
9 the individual upon the government authority by delivery
10 of registered or certified mail.

11 (c) AFFIDAVITS AND SWORN DOCUMENTS.—The gov-
12 ernment authority may file with the court such affidavits
13 and other sworn documents as sustain the validity of the
14 subpoena. The individual may file with the court, within
15 5 days of the date of the authority's filing, affidavits and
16 sworn documents in response to the authority's filing. The
17 court, upon the request of the individual, the government
18 authority, or both, may proceed in camera.

19 (d) PROCEEDINGS AND DECISION ON MOTION.—The
20 court may conduct such proceedings as it deems appro-
21 priate to rule on the motion. All such proceedings shall
22 be completed, and the motion ruled on, within 10 calendar
23 days of the date of the government authority's filing.

24 (e) EXTENSION OF TIME LIMITS FOR GOOD
25 CAUSE.—The court, for good cause shown, may at any

1 time in its discretion enlarge the time limits established
2 by subsections (c) and (d).

3 (f) STANDARD FOR DECISION.—A court may deny a
4 motion under subsection (a) if it finds that there is prob-
5 able cause to believe that the protected health information
6 being sought is relevant to a legitimate law enforcement
7 inquiry being conducted by the government authority, un-
8 less the court finds that the individual's privacy interest
9 outweighs the government authority's need for the infor-
10 mation. The individual shall have the burden of dem-
11 onstrating that the individual's privacy interest outweighs
12 the need established by the government authority for the
13 information.

14 (g) SPECIFIC CONSIDERATIONS WITH RESPECT TO
15 PRIVACY INTEREST.—In determining under subsection (f)
16 whether an individual's privacy interest outweighs the gov-
17 ernment authority's need for the information, the court
18 shall consider—

19 (1) the particular purpose for which the infor-
20 mation was collected by the trustee;

21 (2) the degree to which disclosure of the infor-
22 mation will embarrass, injure, or invade the privacy
23 of the individual;

24 (3) the effect of the disclosure on the individ-
25 ual's future health care;

(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

(5) any other factor deemed relevant by the court.

(h) ATTORNEY'S FEES.—In the case of any motion brought under subsection (a) in which the individual has substantially prevailed, the court, in its discretion, may assess against a government authority a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

(i) NO INTERLOCUTORY APPEAL.—A court ruling denying a motion to quash under this section shall not be deemed a final order and no interlocutory appeal may be taken therefrom by the individual. An appeal of such a ruling may be taken by the individual within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the individual arising out of or based upon the protect health information disclosed.

**SEC. 2173. ACCESS AND CHALLENGE PROCEDURES FOR
OTHER SUBPOENAS.**

(a) IN GENERAL.—A person (other than a government authority seeking protected health information under circumstances described in section 2171(a)) may not ob-

1 tain protected health information about a protected indi-
2 vidual from a health information trustee pursuant to a
3 subpoena under section 2160(a)(2) unless—

4 (1) a copy of the subpoena has been served
5 upon the individual or mailed to the last known ad-
6 dress of the individual on or before the date on
7 which the subpoena was served on the trustee, to-
8 gether with a notice (published by the Secretary
9 under section 2175(2)) of the individual's right to
10 challenge the subpoena, in accordance with sub-
11 section (b); and

12 (2) either—

13 (A) 30 days have passed from the date of
14 service or 30 days have passed from the date of
15 the mailing and within such time period the in-
16 dividual has not initiated a challenge in accord-
17 ance with subsection (b); or

18 (B) disclosure is ordered by a court under
19 such subsection.

20 (b) MOTION TO QUASH.—Within 30 days of the date
21 of service or 30 days of the date of mailing of a subpoena
22 seeking protected health information about a protected in-
23 dividual from a health information trustee under sub-
24 section (a), the individual may file (without filing fee) in
25 any court of competent jurisdiction, a motion to quash the

1 subpoena, with a copy served on the person seeking the
2 information. The individual may oppose, or seek to limit,
3 the subpoena on any grounds that would otherwise be
4 available if the individual were in possession of the infor-
5 mation.

6 (c) STANDARD FOR DECISION.—The court shall
7 grant an individual's motion under subsection (b) if the
8 person seeking the information has not sustained the bur-
9 den of demonstrating that—

10 (1) there are reasonable grounds to believe that
11 the information will be relevant to a lawsuit or other
12 judicial or administrative proceeding; and

13 (2) the need of the person for the information
14 outweighs the privacy interest of the individual.

15 (d) SPECIFIC CONSIDERATIONS WITH RESPECT TO
16 PRIVACY INTEREST.—In determining under subsection (c)
17 whether the need of the person for the information out-
18 weighs the privacy interest of the individual, the court
19 shall consider—

20 (1) the particular purpose for which the infor-
21 mation was collected by the trustee;

22 (2) the degree to which disclosure of the infor-
23 mation will embarrass, injure, or invade the privacy
24 of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the information to the lawsuit or proceeding; and

(5) any other factor deemed relevant by the court.

(e) ATTORNEY'S FEES.—In the case of any motion brought under subsection (b) by an individual against a person in which the individual has substantially prevailed, the court, in its discretion, may assess against the person a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

**SEC. 2174. CONSTRUCTION OF SUBPART; SUSPENSION OF
STATUTE OF LIMITATIONS.**

(a) IN GENERAL.—Nothing in this subpart shall affect the right of a health information trustee to challenge a request for protected health information. Nothing in this subpart shall entitle a protected individual to assert the rights of a health information trustee.

(b) EFFECT OF MOTION ON STATUTE OF LIMITATIONS.—If an individual who is the subject of protected health information files a motion under this subpart which has the effect of delaying the access of a government authority to such information, the period beginning on the date such motion was filed and ending on the date on

1 which the motion is decided shall be excluded in computing
2 any period of limitations within which the government au-
3 thority may commence any civil or criminal action in con-
4 nection with which the access is sought.

5 **SEC. 2175. RESPONSIBILITIES OF SECRETARY.**

6 Not later than July 1, 1996, the Secretary, after no-
7 tice and opportunity for public comment, shall develop and
8 disseminate brief, clear, and easily understood model no-
9 tices—

10 (1) for use under subsection (c) of section
11 2171, detailing the rights of a protected individual
12 who wishes to challenge, under section 2172, the dis-
13 closure of protected health information about the in-
14 dividual under such subsection; and

15 (2) for use under subsection (a) of section
16 2173, detailing the rights of a protected individual
17 who wishes to challenge, under subsection (b) of
18 such section, the disclosure of protected health infor-
19 mation about the individual under such section.

20 **Subpart D—Miscellaneous Provisions**

21 **SEC. 2181. PAYMENT CARD AND ELECTRONIC PAYMENT**
22 **TRANSACTIONS.**

23 (a) **PAYMENT FOR HEALTH CARE THROUGH CARD**
24 **OR ELECTRONIC MEANS.**—If a protected individual pays
25 a health information trustee for health care by presenting

1 a debit, credit, or other payment card or account number,
2 or by any other electronic payment means, the trustee may
3 disclose to a person described in subsection (b) only such
4 protected health information about the individual as is
5 necessary for the processing of the payment transaction
6 or the billing or collection of amounts charged to, debited
7 from, or otherwise paid by, the individual using the card,
8 number, or other electronic payment means.

9 (b) TRANSACTION PROCESSING.—A person who is a
10 debit, credit, or other payment card issuer, is otherwise
11 directly involved in the processing of payment transactions
12 involving such cards or other electronic payment trans-
13 actions, or is otherwise directly involved in the billing or
14 collection of amounts paid through such means, may only
15 use or disclose protected health information about a pro-
16 tected individual that has been disclosed in accordance
17 with subsection (a) when necessary for—

18 (1) the authorization, settlement, billing or col-
19 lection of amounts charged to, debited from, or oth-
20 erwise paid by, the individual using a debit, credit,
21 or other payment card or account number, or by
22 other electronic payment means;

23 (2) the transfer of receivables, accounts, or in-
24 terest therein;

(3) the audit of the credit, debit, or other payment card account information;

(4) compliance with Federal, State, or local law; or

(5) a properly authorized civil, criminal, or regulatory investigation by Federal, State, or local authorities.

**SEC. 2182. ACCESS TO PROTECTED HEALTH INFORMATION
OUTSIDE OF THE UNITED STATES.**

(a) IN GENERAL.—Notwithstanding the provisions of subpart B, and except as provided in subsection (b), a health information trustee may not permit any person who is not in a State to have access to protected health information about a protected individual unless one or more of the following conditions exist:

(1) SPECIFIC AUTHORIZATION.—The individual has specifically consented to the provision of such access outside of the United States in an authorization that meets the requirements of section 2152.

(2) EQUIVALENT PROTECTION.—The provision of such access is authorized under this part and the Secretary has determined that there are fair information practices for protected health information in the jurisdiction where the access will be provided that provide protections for individuals and pro-

1 tected health information that are equivalent to the
2 protections provided for by this part.

3 (3) ACCESS REQUIRED BY LAW.—The provision
4 of such access is required under—

5 (A) a Federal statute; or

6 (B) a treaty or other international agree-
7 ment applicable to the United States.

8 (b) EXCEPTIONS.—Subsection (a) does not apply
9 where the provision of access to protected health informa-
10 tion—

11 (1) is to a foreign public health authority;

12 (2) is authorized under section 2154 (relating
13 to next of kin and directory information), 2156 (re-
14 lating to health research), or 2157 (relating to emer-
15 gency circumstances); or

16 (3) is necessary for the purpose of providing for
17 payment for health care that has been provided to
18 an individual.

19 **SEC. 2183. STANDARDS FOR ELECTRONIC DOCUMENTS AND**
20 **COMMUNICATIONS.**

21 (a) STANDARDS.—Not later than July 1, 1996, the
22 Secretary, after notice and opportunity for public com-
23 ment and in consultation with appropriate private stand-
24 ard-setting organizations and other interested parties,
25 shall establish standards with respect to the creation,

1 transmission, receipt, and maintenance, in electronic and
2 magnetic form, of each type of written document specifi-
3 cally required or authorized under this part. Where a sig-
4 nature is required under any other provision of this part,
5 such standards shall provide for an electronic or magnetic
6 substitute that serves the functional equivalent of a signa-
7 ture.

8 (b) TREATMENT OF COMPLYING DOCUMENTS AND
9 COMMUNICATIONS.—An electronic or magnetic document
10 or communication that satisfies the standards established
11 under subsection (a) with respect to such document or
12 communication shall be treated as satisfying the require-
13 ments of this part that apply to an equivalent written doc-
14 ument.

15 **SEC. 2184. DUTIES AND AUTHORITIES OF AFFILIATED PER-**
16 **SONS.**

17 (a) REQUIREMENTS ON TRUSTEES.—

18 (1) PROVISION OF INFORMATION.—A health in-
19 formation trustee may provide protected health in-
20 formation to a person who, with respect to the trust-
21 ee, is an affiliated person and may permit the affili-
22 ated person to use such information, only for the
23 purpose of conducting, supporting, or facilitating an
24 activity that the trustee is authorized to undertake.

1 (2) NOTICE TO AFFILIATED PERSON.—A health
2 information trustee shall notify a person who, with
3 respect to the trustee, is an affiliated person of any
4 duties under this part that the affiliated person is
5 required to fulfill and of any authorities under this
6 part that the affiliated person is authorized to exer-
7 cise.

8 (b) DUTIES OF AFFILIATED PERSONS.—

9 (1) IN GENERAL.—An affiliated person shall
10 fulfill any duty under this part that—

11 (A) the health information trustee with
12 whom the person has an agreement or relation-
13 ship described in section 2140(c)(1)(C) is re-
14 quired to fulfill; and

15 (B) the person has undertaken to fulfill
16 pursuant to such agreement or relationship.

17 (2) CONSTRUCTION OF OTHER SUBPARTS.—
18 With respect to a duty described in paragraph (1),
19 that an affiliated person is required to fulfill, the
20 person shall be considered a health information
21 trustee for purposes of this part. The person shall
22 be subject to subpart E (relating to enforcement)
23 with respect to any such duty that the person fails
24 to fulfill.

(3) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not relieve a health information trustee of any duty or liability under this part.

(c) AUTHORITIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person may only exercise an authority under this part that the health information trustee with whom the person is affiliated may exercise and that the person has been given by the trustee pursuant to an agreement or relationship described in section 2140(c)(1)(C). With respect to any such authority, the person shall be considered a health information trustee for purposes of this part. The person shall be subject to subpart E (relating to enforcement) with respect to any act that exceeds such authority.

(2) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not affect the authority of a health information trustee under this part.

SEC. 2185. AGENTS AND ATTORNEYS.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), a person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to act as an agent, attorney, proxy,

1 or other legal representative for a protected individual or
2 the estate of a protected individual, or otherwise to exer-
3 cise the rights of the individual or estate, may, to the ex-
4 tent authorized, exercise and discharge the rights of the
5 individual or estate under this part.

6 (b) HEALTH CARE POWER OF ATTORNEY.—A person
7 who is authorized by law (on grounds other than an indi-
8 vidual's minority), or by an instrument recognized under
9 law, to make decisions about the provision of health care
10 to an individual who is incapacitated may exercise and dis-
11 charge the rights of the individual under this part to the
12 extent necessary to effectuate the terms or purposes of
13 the grant of authority.

14 (c) NO COURT DECLARATION.—If a health care pro-
15 vider determines that an individual, who has not been de-
16 clared to be legally incompetent, suffers from a medical
17 condition that prevents the individual from acting know-
18 ingly or effectively on the individual's own behalf, the right
19 of the individual to authorize disclosure under section
20 2152 may be exercised and discharged in the best interest
21 of the individual by—

22 (1) a person described in subsection (b) with re-
23 spect to the individual;

24 (2) a person described in subsection (a) with re-
25 spect to the individual, but only if a person de-

scribed in paragraph (1) cannot be contacted after a reasonable effort;

(3) the next of kin of the individual, but only if a person described in paragraph (1) or (2) cannot be contacted after a reasonable effort; or

(4) the health care provider, but only if a person described in paragraph (1), (2), or (3) cannot be contacted after a reasonable effort.

SEC. 2186. MINORS.

(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual, except as provided in section 2185; or

(2) who, acting alone, has the legal capacity to apply for and obtain health care and has sought such care, the individual shall exercise all rights of an individual under this part with respect to protected health information relating to such care.

(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

(1) under 14 years of age, all the individual's rights under this part shall be exercised through the parent or legal guardian of the individual; or

1 (2) 14, 15, 16, or 17 years of age, the right of
2 inspection (under section 2141), the right of amend-
3 ment (under section 2142), and the right to author-
4 ize disclosure of protected health information (under
5 section 2152) of the individual may be exercised ei-
6 ther by the individual or by the parent or legal
7 guardian of the individual.

8 **SEC. 2187. MAINTENANCE OF CERTAIN PROTECTED**
9 **HEALTH INFORMATION.**

10 (a) IN GENERAL.—A State shall establish a process
11 under which the protected health information described in
12 subsection (b) that is maintained by a person described
13 in subsection (c) is delivered to, and maintained by, the
14 State or an individual or entity designated by the State.

15 (b) INFORMATION DESCRIBED.—The protected
16 health information referred to in subsection (a) is pro-
17 tected health information that—

18 (1) is recorded in any form or medium;

19 (2) is created by—

20 (A) a health care provider; or

21 (B) a health benefit plan sponsor that pro-
22 vides benefits in the form of items and services
23 to enrollees and not in the form of reimburse-
24 ment for items and services; and

1 (3) relates in any way to the past, present, or
 2 future physical or mental health or condition or
 3 functional status of a protected individual or the
 4 provision of health care to a protected individual.

5 (c) PERSONS DESCRIBED.—A person referred to in
 6 subsection (a) is any of the following:

7 (A) A health care facility previously located
 8 in the State that has closed.

9 (B) A professional practice previously op-
 10 erated by a health care provider in the State
 11 that has closed.

12 (C) A health benefit plan sponsor that—
 13 (i) previously provided benefits in the
 14 form of items and services to enrollees in
 15 the State; and

16 (ii) has ceased to do business.

17 **Subpart E—Enforcement**

18 **SEC. 2191. CIVIL ACTIONS.**

19 (a) IN GENERAL.—Any individual whose right under
 20 this part has been knowingly or negligently violated—

21 (1) by a health information trustee, or any
 22 other person, who is not described in paragraph (2),
 23 (3), (4), or (5) may maintain a civil action for actual
 24 damages and for equitable relief against the health
 25 information trustee or other person;

1 (2) by an officer or employee of the United
2 States while the officer or employee was acting with-
3 in the scope of the office or employment may main-
4 tain a civil action for actual damages and for equi-
5 table relief against the United States;

6 (3) by an officer or employee of any government
7 authority of a State that has waived its sovereign
8 immunity to a claim for damages resulting from a
9 violation of this part while the officer or employee
10 was acting within the scope of the office or employ-
11 ment may maintain a civil action for actual damages
12 and for equitable relief against the State govern-
13 ment;

14 (4) by an officer or employee of a government
15 of a State that is not described in paragraph (3)
16 may maintain a civil action for actual damages and
17 for equitable relief against the officer or employee;
18 or

19 (5) by an officer or employee of a government
20 authority while the officer or employee was not act-
21 ing within the scope of the office or employment
22 may maintain a civil action for actual damages and
23 for equitable relief against the officer or employee.

24 (b) KNOWING VIOLATIONS.—Any individual entitled
25 to recover actual damages under this section because of

1 a knowing violation of a provision of this part (other than
2 subsection (c) or (d) of section 2151) shall be entitled to
3 recover the amount of the actual damages demonstrated
4 or \$5000, whichever is greater.

5 (c) ACTUAL DAMAGES.—For purposes of this section,
6 the term “actual damages” includes damages paid to com-
7 pensate an individual for nonpecuniary losses such as
8 physical and mental injury as well as damages paid to
9 compensate for pecuniary losses.

10 (d) PUNITIVE DAMAGES; ATTORNEY’S FEES.—In
11 any action brought under this section in which the com-
12 plainant has prevailed because of a knowing violation of
13 a provision of this part (other than subsection (c) or (d)
14 of section 2151), the court may, in addition to any relief
15 awarded under subsections (a) and (b), award such puni-
16 tive damages as may be warranted. In such an action, the
17 court, in its discretion, may allow the prevailing party a
18 reasonable attorney’s fee (including expert fees) as part
19 of the costs, and the United States shall be liable for costs
20 the same as a private person.

21 (e) LIMITATION.—A civil action under this section
22 may not be commenced more than 2 years after the date
23 on which the aggrieved individual discovered the violation
24 or the date on which the aggrieved individual had a rea-

1 sonable opportunity to discover the violation, whichever oc-
2 curs first.

3 (f) INSPECTION AND AMENDMENT.—If a health in-
4 formation trustee has established a formal internal proce-
5 dure that allows an individual who has been denied inspec-
6 tion or amendment of protected health information to ap-
7 peal the denial, the individual may not maintain a civil
8 action in connection with the denial until the earlier of—

9 (1) the date the appeal procedure has been ex-
10 hausted; or

11 (2) the date that is 4 months after the date on
12 which the appeal procedure was initiated.

13 (g) NO LIABILITY FOR PERMISSIBLE DISCLO-
14 SURES.—A health information trustee who makes a disclo-
15 sure of protected health information about a protected in-
16 dividual that is permitted by this part and not otherwise
17 prohibited by State or Federal statute shall not be liable
18 to the individual for the disclosure under common law.

19 (h) NO LIABILITY FOR INSTITUTIONAL REVIEW
20 BOARD DETERMINATIONS.—If the members of a certified
21 institutional review board have in good faith determined
22 that an approved health research project is of sufficient
23 importance so as to outweigh the intrusion into the privacy
24 of an individual pursuant to section 2156(a)(1), the mem-
25 bers, the board, and the parent institution of the board

1 shall not be liable to the individual as a result of such
2 determination.

3 (i) GOOD FAITH RELIANCE ON CERTIFICATION.—A
4 health information trustee who relies in good faith on a
5 certification by a government authority or other person
6 and discloses protected health information about an indi-
7 vidual in accordance with this part shall not be liable to
8 the individual for such disclosure.

9 **SEC. 2192. CIVIL MONEY PENALTIES.**

10 (a) VIOLATION.—Any health information trustee who
11 the Secretary determines has demonstrated a pattern or
12 practice of failure to comply with the provisions of this
13 part shall be subject, in addition to any other penalties
14 that may be prescribed by law, to a civil money penalty
15 of not more than \$10,000 for each such failure. In deter-
16 mining the amount of any penalty to be assessed under
17 the procedures established under subsection (b), the Sec-
18 retary shall take into account the previous record of com-
19 pliance of the person being assessed with the applicable
20 requirements of this part and the gravity of the violation.

21 (b) PROCEDURES FOR IMPOSITION OF PENALTIES.—
22 The provisions of section 1128A of the Social Security Act
23 (other than subsections (a) and (b)) shall apply to the im-
24 position of a civil monetary penalty under this section in
25 the same manner as such provisions apply with respect

1 to the imposition of a penalty under section 1128A of such
2 Act.

3 **SEC. 2193. ALTERNATIVE DISPUTE RESOLUTION.**

4 (a) IN GENERAL.—Not later than July 1, 1996, the
5 Secretary shall, by regulation, develop alternative dispute
6 resolution methods for use by individuals, health informa-
7 tion trustees, and other persons in resolving claims under
8 section 2191.

9 (b) EFFECT ON INITIATION OF CIVIL ACTIONS.—

10 (1) IN GENERAL.—Subject to paragraph (2),
11 the regulations established under subsection (a) may
12 provide that an individual alleging that a right of
13 the individual under this part has been violated shall
14 pursue at least one alternative dispute resolution
15 method developed under such subsection as a condi-
16 tion precedent to commencing a civil action under
17 section 2191.

18 (2) LIMITATION.—Such regulations may not re-
19 quire an individual to refrain from commencing a
20 civil action to pursue one or more alternative dispute
21 resolution method for a period that is greater than
22 6 months.

23 (3) SUSPENSION OF STATUTE OF LIMITA-
24 TIONS.—The regulations established by the Sec-
25 retary under subsection (a) may provide that a pe-

riod in which an individual described in paragraph (1) pursues (as defined by the Secretary) an alternative dispute resolution method under this section shall be excluded in computing the period of limitations under section 2191(e).

(c) METHODS.—The methods under subsection (a) shall include at least the following:

(1) ARBITRATION.—The use of arbitration.

(2) MEDIATION.—The use of mediation.

(3) EARLY OFFERS OF SETTLEMENT.—The use of a process under which parties make early offers of settlement.

(d) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under subsection (a), the Secretary shall ensure that the methods promote the resolution of claims in a manner that—

(1) is affordable for the parties involved;

(2) provides for timely and fair resolution of claims; and

(3) provides for reasonably convenient access to dispute resolution for individuals.

SEC. 2194. AMENDMENTS TO CRIMINAL LAW.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 89 the following:

1 **“CHAPTER 90—PROTECTED HEALTH**

2 **INFORMATION**

“Sec.

“1831. Definitions.

“1832. Obtaining protected health information under false pretenses.

“1833. Monetary gain from obtaining protected health information under false pretenses.

“1834. Knowing and unlawful obtaining of protected health information.

“1835. Monetary gain from knowing and unlawful obtaining of protected health information.

“1836. Knowing and unlawful use or disclosure of protected health information.

“1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information.

3 **“§ 1831. Definitions**

4 “As used in this chapter—

5 “(1) the term ‘health information trustee’ has
6 the meaning given such term in section 2140(b)(6)
7 of the Affordable Health Care Now Act of 1994;

8 “(2) the term ‘protected health information’ has
9 the meaning given such term in section 2140(a)(3)
10 of such Act; and

11 “(3) the term ‘protected individual’ has the
12 meaning given such term in section 2140(a)(4) of
13 such Act.

14 **“§ 1832. Obtaining protected health information** 15 **under false pretenses**

16 “Whoever under false pretenses—

17 “(1) requests or obtains protected health infor-
18 mation from a health information trustee; or

19 “(2) obtains from a protected individual an au-
20 thorization for the disclosure of protected health in-

1 formation about the individual maintained by a
2 health information trustee;
3 shall be fined under this title or imprisoned not more than
4 5 years, or both.

5 **“§ 1833. Monetary gain from obtaining protected**
6 **health information under false pretenses**

7 “Whoever under false pretenses—

8 “(1) requests or obtains protected health infor-
9 mation from a health information trustee with the
10 intent to sell, transfer, or use such information for
11 profit or monetary gain; or

12 “(2) obtains from a protected individual an au-
13 thorization for the disclosure of protected health in-
14 formation about the individual maintained by a
15 health information trustee with the intent to sell,
16 transfer, or use such authorization for profit or
17 monetary gain;

18 and knowingly sells, transfers, or uses such information
19 or authorization for profit or monetary gain shall be fined
20 under this title or imprisoned not more than 10 years, or
21 both.

22 **“§ 1834. Knowing and unlawful obtaining of pro-**
23 **tected health information**

24 “Whoever knowingly obtains protected health infor-
25 mation from a health information trustee in violation of

1 part 2 of subtitle B of title II of the Affordable Health
2 Care Now Act of 1994, knowing that such obtaining is
3 unlawful, shall be fined under this title or imprisoned not
4 more than 5 years, or both.

5 **“§ 1835. Monetary gain from knowing and unlawful**
6 **obtaining of protected health information**

7 “Whoever knowingly—

8 “(1) obtains protected health information from
9 a health information trustee in violation of part 2 of
10 subtitle B of title II of the Affordable Health Care
11 Now Act of 1994, knowing that such obtaining is
12 unlawful and with the intent to sell, transfer, or use
13 such information for profit or monetary gain; and

14 “(2) knowingly sells, transfers, or uses such in-
15 formation for profit or monetary gain;

16 shall be fined under this title or imprisoned not more than
17 10 years, or both.

18 **“§ 1836. Knowing and unlawful use or disclosure of**
19 **protected health information**

20 “Whoever knowingly uses or discloses protected
21 health information in violation of part 2 of subtitle B of
22 title II of the Affordable Health Care Now Act of 1994,
23 knowing that such use or disclosure is unlawful, shall be
24 fined under this title or imprisoned not more than 5 years,
25 or both.

1 **“§ 1837. Monetary gain from knowing and unlawful**
 2 **sale, transfer, or use of protected health**
 3 **information**

4 “Whoever knowingly sells, transfers, or uses pro-
 5 tected health information in violation of part 2 of subtitle
 6 B of title II of the Affordable Health Care Now Act of
 7 1994, knowing that such sale, transfer, or use is unlawful,
 8 shall be fined under this title or imprisoned not more than
 9 10 years, or both.”.

10 (b) CLERICAL AMENDMENT.—The table of chapters
 11 for part I of title 18, United States Code, is amended by
 12 inserting after the item relating to chapter 89 the follow-
 13 ing:

“90. Protected health information 1831”.

14 **Subpart F—Amendments to Title 5, United States**
 15 **Code**

16 **SEC. 2195. AMENDMENTS TO TITLE 5, UNITED STATES**
 17 **CODE.**

18 (a) NEW SUBSECTION.—Section 552a of title 5,
 19 United States Code, is amended by adding at the end the
 20 following:

21 “(w) MEDICAL EXEMPTIONS.—The head of an agen-
 22 cy that is a health information trustee (as defined in sec-
 23 tion 2140(b)(6) of the Affordable Health Care Now Act
 24 of 1994) shall promulgate rules, in accordance with the

1 requirements (including general notice) of subsections
 2 (b)(1), (b)(2), (b)(3), (c), and (e) of section 553 of this
 3 title, to exempt a system of records within the agency, to
 4 the extent that the system of records contains protected
 5 health information (as defined in section 2140(a)(3) of
 6 such Act), from all provisions of this section except sub-
 7 sections (e)(1), (e)(2), subparagraphs (A) through (C) and
 8 (E) through (I) of subsection (e)(4), and subsections
 9 (e)(5), (e)(6), (e)(9), (e)(12), (l), (n), (o), (p), (q), (r), and
 10 (u).”.

11 (b) REPEAL.—Section 552a(f)(3) of title 5, United
 12 States Code, is amended by striking “pertaining to him,”
 13 and all that follows through the semicolon and inserting
 14 “pertaining to the individual;”.

15 **Subpart G—Regulations, Research, and Education;**
 16 **Effective Dates; Applicability; and Relationship**
 17 **to Other Laws**

18 **SEC. 2196. REGULATIONS; RESEARCH AND EDUCATION.**

19 (a) REGULATIONS.—Not later than July 1, 1996, the
 20 Secretary shall prescribe regulations to carry out this part.

21 (b) RESEARCH AND TECHNICAL SUPPORT.—The
 22 Secretary may sponsor—

23 (1) research relating to the privacy and security
 24 of protected health information;

1 (2) the development of consent forms governing
2 disclosure of such information; and

3 (3) the development of technology to implement
4 standards regarding such information.

5 (c) EDUCATION.—The Secretary shall establish edu-
6 cation and awareness programs—

7 (1) to foster adequate security practices by
8 health information trustees;

9 (2) to train personnel of health information
10 trustees respecting the duties of such personnel with
11 respect to protected health information; and

12 (3) to inform individuals and employers who
13 purchase health care respecting their rights with re-
14 spect to such information.

15 **SEC. 2197. EFFECTIVE DATES.**

16 (a) IN GENERAL.—Except as provided in subsection
17 (b), this part, and the amendments made by this part,
18 shall take effect on January 1, 1997.

19 (b) PROVISIONS EFFECTIVE IMMEDIATELY.—A pro-
20 vision of this part shall take effect on the date of the en-
21 actment of this Act if the provision—

22 (1) imposes a duty on the Secretary to develop,
23 establish, or promulgate regulations, guidelines, no-
24 tices, statements, or education and awareness pro-
25 grams; or

(2) authorizes the Secretary to sponsor research or the development of forms or technology.

SEC. 2198. APPLICABILITY.

(a) PROTECTED HEALTH INFORMATION.—Except as provided in subsections (b) and (c), the provisions of this part shall apply to any protected health information that is received, created, used, maintained, or disclosed by a health information trustee in a State on or after January 1, 1997, regardless of whether the information existed or was disclosed prior to such date.

(b) EXCEPTION.—

(1) IN GENERAL.—The provisions of this part shall not apply to a trustee described in paragraph (2), except with respect to protected health information that is received by the trustee on or after January 1, 1997.

(2) APPLICABILITY.—A trustee referred to in paragraph (1) is—

(A) a health researcher; or

(B) a person who, with respect to specific protected health information, received the information—

(i) pursuant to—

(I) section 2157 (relating to emergency circumstances);

1 (II) section 2158 (relating to ju-
2 dicial and administrative purposes);

3 (III) section 2159 (relating to
4 law enforcement); or

5 (IV) section 2160 (relating to
6 subpoenas, warrants, and search war-
7 rants); or

8 (ii) while acting in whole or in part in
9 the capacity of an officer or employee of a
10 person described in clause (i).

11 (c) AUTHORIZATIONS FOR DISCLOSURES.—An au-
12 thorization for the disclosure of protected health informa-
13 tion about a protected individual that is executed by the
14 individual before January 1, 1997, and is recognized and
15 valid under State law on December 31, 1996, shall remain
16 valid and shall not be subject to the requirements of sec-
17 tion 2152 until January 1, 1998, or the occurrence of the
18 date or event (if any) specified in the authorization upon
19 which the authorization expires, whichever occurs earlier.

20 **SEC. 2199. RELATIONSHIP TO OTHER LAWS.**

21 (a) STATE LAW.—Except as otherwise provided in
22 subsections (b), (c), (d), and (f), a State may not estab-
23 lish, continue in effect, or enforce any State law to the
24 extent that the law is inconsistent with, or imposes addi-
25 tional requirements with respect to, any of the following:

(1) A duty of a health information trustee under this part.

(2) An authority of a health information trustee under this part to disclose protected health information.

(3) A provision of subpart C (relating to access procedures and challenge rights), subpart D (miscellaneous provisions), or subpart (E) (relating to enforcement).

(b) LAWS RELATING TO PUBLIC HEALTH AND MENTAL HEALTH.—This part does not preempt, supersede, or modify the operation of any State law regarding public health or mental health to the extent that the law prohibits or regulates a disclosure of protected health information that is permitted under this part.

(c) CRIMINAL PENALTIES.—A State may establish and enforce criminal penalties with respect to a failure to comply with a provision of this part.

(d) PRIVILEGES.—A privilege that a person has under law in a court of a State or the United States or under the rules of any agency of a State or the United States may not be diminished, waived, or otherwise affected by—

(1) the execution by a protected individual of an authorization for disclosure of protected health in-

1 formation under this part, if the authorization is ex-
2 ecuted for the purpose of receiving health care or
3 providing for the payment for health care; or

4 (2) any provision of this part that authorizes
5 the disclosure of protected health information for the
6 purpose of receiving health care or providing for the
7 payment for health care.

8 (e) DEPARTMENT OF VETERANS AFFAIRS.—The lim-
9 itations on use and disclosure of protected health informa-
10 tion under this part shall not be construed to prevent any
11 exchange of such information within and among compo-
12 nents of the Department of Veterans Affairs that deter-
13 mine eligibility for or entitlement to, or that provide, bene-
14 fits under laws administered by the Secretary of Veterans
15 Affairs.

16 (f) CERTAIN DUTIES UNDER STATE OR FEDERAL
17 LAW.—This part shall not be construed to preempt, super-
18 sede, or modify the operation of any of the following:

19 (1) Any law that provides for the reporting of
20 vital statistics such as birth or death information.

21 (2) Any law requiring the reporting of abuse or
22 neglect information about any individual.

23 (3) Subpart II of part E of title XXVI of the
24 Public Health Service Act (relating to notifications

1 of emergency response employees of possible expo-
2 sure to infectious diseases).

3 (4) The Americans with Disabilities Act of
4 1990.

5 (5) Any Federal or State statute that estab-
6 lishes a privilege for records used in health profes-
7 sional peer review activities.

8 (g) SECRETARIAL AUTHORITY.—

9 (1) SECRETARY OF HEALTH AND HUMAN SERV-
10 ICES.—A provision of this part does not preempt,
11 supersede, or modify the operation of section 543 of
12 the Public Health Service Act, except to the extent
13 that the Secretary of Health and Human Services
14 determines through regulations promulgated by such
15 Secretary that the provision provides greater protec-
16 tion for protected health information, and the rights
17 of protected individuals, than is provided under such
18 section 543.

19 (2) SECRETARY OF VETERANS AFFAIRS.—A
20 provision of this part does not preempt, supersede,
21 or modify the operation of section 7332 of title 38,
22 United States Code, except to the extent that the
23 Secretary of Veterans Affairs determines through
24 regulations promulgated by such Secretary that the
25 provision provides greater protection for protected

1 health information, and the rights of protected indi-
 2 viduals, than is provided under such section 7332.

3 **Subtitle C—Deduction for Cost of** 4 **Catastrophic Health Plan; Medi-** 5 **cal Savings Accounts**

6 **SEC. 2201. INDIVIDUALS ALLOWED DEDUCTION FROM** 7 **GROSS INCOME FOR COST OF CATASTROPHIC** 8 **HEALTH PLAN.**

9 (a) IN GENERAL.—Subsection (a) of section 62 of the
 10 Internal Revenue Code of 1986, as amended by title I,
 11 is amended by inserting after paragraph (16) the following
 12 new paragraph:

13 “(17) MEDICAL EXPENSES ATTRIBUTABLE TO
 14 CATASTROPHIC HEALTH PLAN COVERAGE.—

15 “(A) IN GENERAL.—The deduction allowed
 16 by section 213 to the extent attributable to cov-
 17 erage under a catastrophic health plan (as de-
 18 fined in section 220(c)(2)).

19 “(B) EXCEPTION.—Subparagraph (A)
 20 shall not apply to coverage of an individual who
 21 has coverage described in section
 22 220(c)(1)(B)(i).”.

23 (b) COORDINATION WITH DEDUCTION FOR OTHER
 24 MEDICAL EXPENSES.—Subsection (a) of section 213 of
 25 such Code is amended to read as follows:

1 “(a) ALLOWANCE OF DEDUCTION.—There shall be
 2 allowed as a deduction the expenses paid during the tax-
 3 able year, not compensated by insurance or otherwise, for
 4 medical care of the taxpayer, his spouse, or a dependent
 5 (as defined in section 152) in an amount equal to the sum
 6 of—

7 “(1) the portion of such expenses attributable
 8 to coverage under a catastrophic health plan (as de-
 9 fined in section 220(c)(2)), and

10 “(2) the excess of such expenses (other than ex-
 11 penses described in paragraph (1)) over 7.5 percent
 12 of the adjusted gross income of the taxpayer.”

13 (c) EFFECTIVE DATE.—The amendments made by
 14 this section shall apply to taxable years beginning after
 15 December 31, 1993.

16 **SEC. 2202. MEDICAL SAVINGS ACCOUNTS.**

17 (a) IN GENERAL.—Part VII of subchapter B of chap-
 18 ter 1 of the Internal Revenue Code of 1986 (relating to
 19 additional itemized deductions for individuals) is amended
 20 by redesignating section 220 as section 221 and by insert-
 21 ing after section 219 the following new section:

22 **“SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

23 “(a) DEDUCTION ALLOWED.—

24 “(1) IN GENERAL.—In the case of an eligible
 25 individual, there shall be allowed as a deduction the

1 applicable percentage of the amounts paid in cash
2 during the taxable year by or on behalf of such indi-
3 vidual to a medical savings account for the benefit
4 of such individual and (if any) such individual's
5 spouse and dependents if such spouse and depend-
6 ents are eligible individuals.

7 “(2) APPLICABLE PERCENTAGE.—For purposes
8 of paragraph (1), the term ‘applicable percentage’
9 means—

10 “(A) 25 percent for taxable years begin-
11 ning in 1994 or 1995,

12 “(B) 50 percent for taxable years begin-
13 ning in 1996 or 1997, and

14 “(C) 100 percent for taxable years begin-
15 ning after 1997.

16 “(b) LIMITATIONS.—

17 “(1) ONLY 1 ACCOUNT PER FAMILY.—Except as
18 provided in regulations prescribed by this Secretary,
19 no deduction shall be allowed under subsection (a)
20 for amounts paid to any medical savings account for
21 the benefit of an individual, such individual's spouse,
22 or any dependent of such individual or spouse if
23 such individual, spouse, or dependent is a beneficiary
24 of any other medical savings account.

1 “(2) DOLLAR LIMITATION.—The amount allow-
2 able as a deduction under subsection (a) for the tax-
3 able year shall not exceed whichever of the following
4 is the least:

5 “(A) The lowest deductible under any cata-
6 strophic health plan providing coverage to any
7 beneficiary of the medical savings account.

8 “(B) \$2,500 (\$5,000 if the catastrophic
9 health plan covering the taxpayer provides cov-
10 erage for more than 1 individual).

11 “(C) The excess of—

12 “(i) the applicable target actuarial
13 value for standard coverage established
14 under section 1102(c)(2) of the Affordable
15 Health Care Now Act of 1994, over

16 “(ii) the deduction allowed by section
17 213 for the taxable year to the extent at-
18 tributable to coverage under a catastrophic
19 health plan.

20 Under rules of the Secretary, the target actuar-
21 ial value under subparagraph (C)(i) shall be
22 made applicable to individual and family cov-
23 erage. A beneficiary of such account who has
24 attained age 65 before the close of the taxable
25 year shall not be taken into account in deter-

1 mining the limitation under the preceding sen-
2 tence.

3 “(c) DEFINITIONS.—For purposes of this section—

4 “(1) ELIGIBLE INDIVIDUAL.—

5 “(A) IN GENERAL.—The term ‘eligible in-
6 dividual’ means any individual who is covered
7 under a catastrophic health plan throughout the
8 calendar year in which or with which the tax-
9 able year ends.

10 “(B) LIMITATIONS.—Such term does not
11 include—

12 “(i) an individual who is 65 years of
13 age or older, unless the individual is cov-
14 ered under a catastrophic health plan that
15 is a primary plan (within the meaning of
16 section 1862(b)(2)(A) of the Social Secu-
17 rity Act); and

18 “(ii) an individual who has coverage
19 under a group health plan or health insur-
20 ance plan (other than a plan described in
21 1131(4)(B) of the Affordable Health Care
22 Now Act of 1994) that has either a de-
23 ductible that is less than the minimum de-
24 ductible required under a catastrophic
25 health plan (as defined in paragraph (2))

1 or has an actuarial value that is greater
2 than the value for MedAccess catastrophic
3 coverage (as provided in section 1102(d) of
4 such Act).

5 “(C) DEDUCTION NOT ALLOWED BEFORE
6 1999 TO INDIVIDUALS ELIGIBLE FOR EM-
7 PLOYER-SUBSIDIZED COVERAGE.—In the case
8 of any taxable year beginning before January 1,
9 1999, such term does not include an individ-
10 ual—

11 “(i) who is eligible to participate in
12 any subsidized health plan maintained by
13 an employer of such individual or the
14 spouse of such individual, or

15 “(ii) who is (or whose spouse is) a
16 member of a subsidized class of employees
17 of an employer.

18 The rules of subparagraphs (B) and (C) of sec-
19 tion 213(f)(3) shall apply for purposes of this
20 preceding sentence.

21 “(2) CATASTROPHIC HEALTH PLAN.—For pur-
22 poses of paragraph (1)—

23 “(A) IN GENERAL.—The term ‘cata-
24 strophic health plan’ means a health plan cover-
25 ing specified expenses incurred by an individual

for medical care for such individual and the spouse and dependents (as defined in section 152) of such individual only to the extent such expenses covered by the plan for any calendar year exceed \$1,800 (\$3,600 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual) or such higher amounts as may be specified by the plan.

“(B) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year after 1994, each dollar amount in subparagraph (A) shall be increased by an amount equal to—

“(i) such dollar amount, multiplied by

“(ii) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year.

If any increase under the preceding sentence is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

“(d) MEDICAL SAVINGS ACCOUNTS.—For purposes of this section—

“(1) MEDICAL SAVINGS ACCOUNT.—

“(A) IN GENERAL.—The term ‘medical savings account’ means a trust created or organized in the United States exclusively for the

1 purpose of paying the medical expenses of the
2 beneficiaries of such trust, but only if the writ-
3 ten governing instrument creating the trust
4 meets the following requirements:

5 “(i) Except in the case of a rollover
6 contribution described in subsection (e)(4),
7 no contribution will be accepted unless it is
8 in cash, and contributions will not be ac-
9 cepted in excess of the amount allowed as
10 a deduction under this section for the tax-
11 able year (or would be allowed as such a
12 deduction but for subsection (c)(1)(C)).

13 “(ii) The trustee is a bank (as defined
14 in section 408(n)) or another person who
15 demonstrates to the satisfaction of the Sec-
16 retary that the manner in which such per-
17 son will administer the trust will be con-
18 sistent with the requirements of this sec-
19 tion.

20 “(iii) No part of the trust assets will
21 be invested in life insurance contracts.

22 “(iv) The assets of the trust will not
23 be commingled with other property except
24 in a common trust fund or common invest-
25 ment fund.

1 “(v) The interest of an individual in
2 the balance in his account is nonforfeit-
3 able.

4 “(vi) Under regulations prescribed by
5 the Secretary, rules similar to the rules of
6 section 401(a)(9) shall apply to the dis-
7 tribution of the entire interest of bene-
8 ficiaries of such trust.

9 “(B) TREATMENT OF COMPARABLE AC-
10 COUNTS HELD BY INSURANCE COMPANIES.—
11 For purposes of this section, an account held by
12 an insurance company in the United States
13 shall be treated as a medical savings account
14 (and such company shall be treated as a bank)
15 if—

16 “(i) such account is part of a health
17 insurance plan that includes a catastrophic
18 health plan (as defined in subsection
19 (c)(2)),

20 “(ii) such account is exclusively for
21 the purpose of paying the medical expenses
22 of the beneficiaries of such account who
23 are covered under such catastrophic health
24 plan, and

1 “(iii) the written instrument govern-
2 ing the account meets the requirements of
3 clauses (i), (v), and (vi) of subparagraph
4 (A).

5 “(2) MEDICAL EXPENSES.—

6 “(A) IN GENERAL.—The term ‘medical ex-
7 penses’ means, with respect to an individual,
8 amounts paid or incurred by such individual
9 for—

10 “(i) medical care (as defined in sec-
11 tion 213), or

12 “(ii) long-term care (as defined in
13 paragraph (3)),

14 for such individual, the spouse of such individ-
15 ual, and any dependent (as defined in section
16 152) of such individual, but only to the extent
17 such amounts are not compensated for by in-
18 surance or otherwise.

19 “(B) HEALTH PLAN COVERAGE MAY NOT
20 BE PURCHASED FROM ACCOUNT.—

21 “(i) IN GENERAL.—Such term shall
22 not include any amount paid for coverage
23 under a health plan.

24 “(ii) EXCEPTION.—Clause (i) shall
25 not apply—

1 “(I) in the case of coverage of an
2 individual under 65 years of age
3 under a catastrophic health plan or
4 under a long-term care insurance
5 plan, or

6 “(II) in the case of coverage of
7 an individual 65 years of age or older
8 under a medicare supplemental policy
9 or under a long-term care insurance
10 plan or for payment of premiums
11 under part A or part B of title XVIII
12 of the Social Security Act.

13 “(3) LONG-TERM CARE.—

14 “(A) IN GENERAL.—The term ‘long-term
15 care’ means diagnostic, preventive, therapeutic,
16 rehabilitative, maintenance, or personal care
17 services which are required by, and provided to,
18 a chronically ill individual, which have as their
19 primary purpose the direct provision of needed
20 assistance with 1 or more activities of daily liv-
21 ing (or the alleviation of the conditions neces-
22 sitating such assistance) that the individual is
23 certified under subparagraph (B) as being un-
24 able to perform, and which are provided in a
25 setting other than an acute care unit of a hos-

1 pital pursuant to a continuing plan of care pre-
2 scribed by a physician or registered professional
3 nurse. Such term does not include food or lodg-
4 ing provided in an institutional or other setting,
5 or basic living services associated with the
6 maintenance of a household or participation in
7 community life, such as case management,
8 transportation or legal services, or the perform-
9 ance of home maintenance or household chores.

10 “(B) CHRONICALLY ILL INDIVIDUAL.—The
11 term ‘chronically ill individual’ means an indi-
12 vidual who is certified by a physician or reg-
13 istered professional nurse as being unable to
14 perform at least 3 activities of daily living with-
15 out substantial assistance from another individ-
16 ual. For purposes of this paragraph, the term
17 ‘activities of daily living’ means bathing, dress-
18 ing, eating, toileting, transferring, and walking.

19 “(4) TIME WHEN CONTRIBUTIONS DEEMED
20 MADE.—A contribution shall be deemed to be made
21 on the last day of the preceding taxable year if the
22 contribution is made on account of such taxable year
23 and is made not later than the time prescribed by
24 law for filing the return for such taxable year (not
25 including extensions thereof).

1 “(e) TAX TREATMENT OF DISTRIBUTIONS.—

2 “(1) IN GENERAL.—Any amount paid or dis-
3 tributed out of a medical savings account shall be in-
4 cluded in the gross income of the individual for
5 whose benefit such account was established unless
6 such amount is used exclusively to pay the medical
7 expenses of such individual.

8 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
9 FORE DUE DATE OF RETURN.—Paragraph (1) shall
10 not apply to the distribution of any contribution paid
11 during a taxable year to a medical savings account
12 to the extent that such contribution exceeds the
13 amount allowable as a deduction under subsection
14 (a) if—

15 “(A) such distribution is received by the
16 individual on or before the last day prescribed
17 by law (including extensions of time) for filing
18 such individual’s return for such taxable year,
19 and

20 “(B) such distribution is accompanied by
21 the amount of net income attributable to such
22 excess contribution.

23 Any net income described in subparagraph (B) shall
24 be included in the gross income of the individual for
25 the taxable year in which it is received.

1 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
2 FOR MEDICAL EXPENSES.—

3 “(A) IN GENERAL.—The tax imposed by
4 this chapter for any taxable year in which there
5 is a payment or distribution from a medical
6 savings account which is not used to pay the
7 medical expenses of the individual for whose
8 benefit the account was established shall be in-
9 creased by 10 percent of the amount of such
10 payment or distribution which is includible in
11 gross income under paragraph (1).

12 “(B) ACCOUNT BALANCE LIMITATION.—
13 If—

14 “(i) the tax imposed by this chapter is
15 required to be increased under subpara-
16 graph (A) by reason of a distribution, and

17 “(ii) after such distribution, the ag-
18 gregate balance of all medical savings ac-
19 counts established for the benefit of the in-
20 dividual, is less than the amount of the de-
21 ductible under the catastrophic health plan
22 covering such individual,

23 subparagraph (A) shall be applied by substitut-
24 ing ‘50 percent’ for ‘10 percent’.

1 “(4) ROLLOVERS.—Paragraph (1) shall not
2 apply to any amount paid or distributed out of a
3 medical savings account to the individual for whose
4 benefit the account is maintained if the entire
5 amount received (including money and any other
6 property) is paid into another medical savings ac-
7 count for the benefit of such individual not later
8 than the 60th day after the day on which he received
9 the payment or distribution.

10 “(5) PENALTY FOR MANDATORY DISTRIBUTIONS NOT MADE FROM ACCOUNT.—

12 “(A) IN GENERAL.—If during any taxable
13 year—

14 “(i) there is a payment of a manda-
15 tory distribution expense incurred by a
16 beneficiary of a medical savings account,
17 and

18 “(ii) the person making such payment
19 is not reimbursed for such payment with a
20 distribution from such account before the
21 60th day after such payment,

22 the taxpayer’s tax imposed by this chapter for
23 such taxable year shall be increased by 100 per-
24 cent of the excess of the amount of such pay-

1 ment over the amount of reimbursement made
2 before such 60th day.

3 “(B) MANDATORY DISTRIBUTION EX-
4 PENSE.—For purposes of subparagraph (A),
5 the term ‘mandatory distribution expense’
6 means—

7 “(i) any expense incurred which may
8 be counted towards a deductible, or for a
9 copayment or coinsurance, under the cata-
10 strophic health plan covering such bene-
11 ficiary, and

12 “(ii) in the case of a beneficiary who
13 has attained age 65, any expense for cov-
14 erage described in subsection
15 (d)(2)(B)(ii)(II) and any expense incurred
16 which may be counted toward a deductible,
17 or for a copayment or coinsurance, under
18 title XVIII of the Social Security Act.

19 “(f) TAX TREATMENT OF ACCOUNTS.—

20 “(1) EXEMPTION FROM TAX.—Any medical sav-
21 ings account is exempt from taxation under this sub-
22 title unless such account has ceased to be a medical
23 savings account by reason of paragraph (2) or (3).
24 Notwithstanding the preceding sentence, any such
25 account shall be subject to the taxes imposed by sec-

tion 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

“(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

“(A) IN GENERAL.—If, during any taxable year of the individual for whose benefit the medical savings account was established, such individual engages in any transaction prohibited by section 4975 with respect to the account, the account ceases to be a medical savings account as of the first day of that taxable year.

“(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (e) shall be applied as if there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day) and no portion of such distribution were used to pay medical expenses.

“(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a medical savings account was estab-

lished uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed to that individual and not used to pay medical expenses.

“(g) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

“(1) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

“(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (d).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

“(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this

1 subsection shall be filed at such time and in such manner
2 and furnished to such individuals at such time and in such
3 manner as may be required by those regulations.”

4 (b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL
5 ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
6 of section 62 of such Code is amended by inserting after
7 paragraph (17) the following new paragraph:

8 “(18) MEDICAL SAVINGS ACCOUNTS.—The de-
9 duction allowed by section 220.”

10 (c) DISTRIBUTIONS FROM MEDICAL SAVINGS AC-
11 COUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUC-
12 TION.—Section 213 of such Code is amended by adding
13 at the end thereof the following new subsection:

14 “(g) COORDINATION WITH MEDICAL SAVINGS AC-
15 COUNTS.—The amount otherwise taken into account
16 under subsection (a) as expenses paid for medical care
17 shall be reduced by the amount (if any) of the distribu-
18 tions from any medical savings account of the taxpayer
19 during the taxable year which is not includible in gross
20 income by reason of being used for medical care.”

21 (d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO
22 MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT
23 TAXES.—

24 (1) SOCIAL SECURITY TAXES.—

1 (A) Subsection (a) of section 3121 of such
2 Code is amended by striking “or” at the end of
3 paragraph (20), by striking the period at the
4 end of paragraph (21) and inserting “; or”, and
5 by inserting after paragraph (21) the following
6 new paragraph:

7 “(22) remuneration paid to or on behalf of an
8 employee if (and to the extent that) at the time of
9 payment of such remuneration it is reasonable to be-
10 lieve that a corresponding deduction is allowable
11 under section 220.”

12 (B) Subsection (a) of section 209 of the
13 Social Security Act is amended by striking “or”
14 at the end of paragraph (17), by striking the
15 period at the end of paragraph (18) and insert-
16 ing “; or”, and by inserting after paragraph
17 (18) the following new paragraph:

18 “(19) remuneration paid to or on behalf of an
19 employee if (and to the extent that) at the time of
20 payment of such remuneration it is reasonable to be-
21 lieve that a corresponding deduction is allowable
22 under section 220 of the Internal Revenue Code of
23 1986.”

1 (2) RAILROAD RETIREMENT TAX.—Subsection
2 (e) of section 3231 of such Code is amended by add-
3 ing at the end thereof the following new paragraph:

4 “(10) EMPLOYER CONTRIBUTIONS TO MEDICAL
5 SAVINGS ACCOUNTS.—The term ‘compensation’ shall
6 not include any payment made to or on behalf of an
7 employee if (and to the extent that) at the time of
8 payment of such remuneration it is reasonable to be-
9 lieve that a corresponding deduction is allowable
10 under section 220.”

11 (3) UNEMPLOYMENT TAX.—Subsection (b) of
12 section 3306 of such Code is amended by striking
13 “or” at the end of paragraph (15), by striking the
14 period at the end of paragraph (16) and inserting “;
15 or”, and by inserting after paragraph (16) the fol-
16 lowing new paragraph:

17 “(17) remuneration paid to or on behalf of an
18 employee if (and to the extent that) at the time of
19 payment of such remuneration it is reasonable to be-
20 lieve that a corresponding deduction is allowable
21 under section 220.”

22 (4) WITHHOLDING TAX.—Subsection (a) of sec-
23 tion 3401 of such Code is amended by striking “or”
24 at the end of paragraph (19), by striking the period
25 at the end of paragraph (20) and inserting “; or”,

1 and by inserting after paragraph (20) the following
2 new paragraph:

3 “(21) remuneration paid to or on behalf of an
4 employee if (and to the extent that) at the time of
5 payment of such remuneration it is reasonable to be-
6 lieve that a corresponding deduction is allowable
7 under section 220.”

8 (e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
9 of such Code (relating to tax on excess contributions to
10 individual retirement accounts, certain section 403(b) con-
11 tracts, and certain individual retirement annuities) is
12 amended—

13 (1) by inserting “**MEDICAL SAVINGS AC-**
14 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
15 such section,

16 (2) by redesignating paragraph (2) of sub-
17 section (a) as paragraph (3) and by inserting after
18 paragraph (1) the following:

19 “(2) a medical savings account (within the
20 meaning of section 220(d)),”,

21 (3) by striking “or” at the end of paragraph
22 (1) of subsection (a), and

23 (4) by adding at the end thereof the following
24 new subsection:

1 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS
 2 ACCOUNTS.—For purposes of this section, in the case of
 3 a medical savings account (within the meaning of section
 4 220(d)), the term ‘excess contributions’ means the amount
 5 by which the amount contributed for the taxable year to
 6 the account exceeds the amount excludable from gross in-
 7 come under section 220 for such taxable year. For pur-
 8 poses of this subsection, any contribution which is distrib-
 9 uted out of the medical savings account in a distribution
 10 to which section 220(e)(2) applies shall be treated as an
 11 amount not contributed.”

12 (f) TAX ON PROHIBITED TRANSACTIONS.—Section
 13 4975 of such Code (relating to prohibited transactions)
 14 is amended—

15 (1) by adding at the end of subsection (c) the
 16 following new paragraph:

17 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
 18 COUNTS.—An individual for whose benefit a medical
 19 savings account (within the meaning of section
 20 220(d)) is established shall be exempt from the tax
 21 imposed by this section with respect to any trans-
 22 action concerning such account (which would other-
 23 wise be taxable under this section) if, with respect
 24 to such transaction, the account ceases to be a medi-

cal savings account by reason of the application of section 220(e)(2)(A) to such account.”, and

(2) by inserting “or a medical savings account described in section 220(d)” in subsection (e)(1) after “described in section 408(a)”.

(g) **FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.**—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(1) by inserting “**OR ON MEDICAL SAVINGS ACCOUNTS**” after “**ANNUITIES**” in the heading of such section, and

(2) by adding at the end of subsection (a) the following: “The person required by section 220(h) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of \$50 for each failure unless it is shown that such failure is due to reasonable cause.”

(h) **CLERICAL AMENDMENTS.**—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

“Sec. 220. Medical savings accounts.
“Sec. 221. Cross reference.”

1 (2) The table of sections for chapter 43 of such
2 Code is amended by striking the item relating to sec-
3 tion 4973 and inserting the following:

“Sec. 4973. Tax on excess contributions to individual retirement accounts, medical savings accounts, certain 403(b) contracts, and certain individual retirement annuities.”

4 (3) The table of sections for subchapter B of
5 chapter 68 of such Code is amended by inserting “or
6 on medical savings accounts” after “annuities” in
7 the item relating to section 6693.

8 (i) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 1993.

11 **Subtitle D—Anti-Fraud**

12 **PART 1—ESTABLISHMENT OF ALL-PAYER** 13 **HEALTH CARE FRAUD AND ABUSE CONTROL** 14 **PROGRAM**

15 **SEC. 2301. ALL-PAYER HEALTH CARE FRAUD AND ABUSE** 16 **CONTROL PROGRAM.**

17 (a) IN GENERAL.—Not later than January 1, 1996,
18 the Attorney General shall establish a program—

19 (1) to coordinate Federal, State, and local law
20 enforcement programs to control fraud and abuse
21 with respect to the delivery of and payment for
22 health care in the United States,

(2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(3) in consultation with the Inspector General of the Department of Health and Human Services, to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH THIRD PARTY INSURERS.—In carrying out the program established under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data with representatives of private sponsors of health benefit plans and other providers of health insurance.

(d) REGULATIONS.—

1 (1) IN GENERAL.—The Attorney General shall
2 by regulation establish standards to carry out the
3 program under subsection (a).

4 (2) INFORMATION STANDARDS.—

5 (A) IN GENERAL.—Such standards shall
6 include standards relating to the furnishing of
7 information by health insurers (including self-
8 insured health benefit plans), providers, and
9 others to enable the Attorney General to carry
10 out the program (including coordination with
11 law enforcement agencies under subsection (b)
12 and third party insurers under subsection (c)).

13 (B) CONFIDENTIALITY.—Such standards
14 shall include procedures to assure that such in-
15 formation is provided and utilized in a manner
16 that protects the confidentiality of the informa-
17 tion and the privacy of individuals receiving
18 health care services.

19 (C) QUALIFIED IMMUNITY FOR PROVIDING
20 INFORMATION.—The provisions of section
21 1157(a) of the Social Security Act (relating to
22 limitation on liability) shall apply to a person
23 providing information to the Attorney General
24 under the program under this section, with re-
25 spect to the Attorney General's performance of

1 duties under the program, in the same manner
2 as such section applies to information provided
3 to organizations with a contract under part B
4 of title XI of such Act, with respect to the per-
5 formance of such a contract.

6 **SEC. 2302. AUTHORIZATION OF ADDITIONAL APPROPRIA-**
7 **TIONS FOR INVESTIGATORS AND OTHER PER-**
8 **SONNEL.**

9 In addition to any other amounts authorized to be
10 appropriated to the Attorney General for health care anti-
11 fraud and abuse activities for a fiscal year, there are au-
12 thorized to be appropriated such sums as may be nec-
13 essary to enable the Attorney General to conduct inves-
14 tigations of allegations of health care fraud and otherwise
15 carry out the program established under section 2301 in
16 a fiscal year.

17 **SEC. 2303. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE**
18 **TRUST FUND.**

19 (a) ESTABLISHMENT.—There is hereby created on
20 the books of the Treasury of the United States a trust
21 fund to be known as the “Anti-Fraud and Abuse Trust
22 Fund” (in this section referred to as the “Trust Fund”).
23 The Trust Fund shall consist of such amounts as may be
24 deposited in, or appropriated to, such Trust Fund as pro-

1 vided in this part and section 1128A(f)(3) of the Social
2 Security Act.

3 (b) MANAGEMENT.—

4 (1) IN GENERAL.—The Trust Fund shall be
5 managed by the Attorney General through a Manag-
6 ing Trustee designated by the Attorney General.

7 (2) INVESTMENT OF FUNDS.—It shall be the
8 duty of the Managing Trustee to invest such portion
9 of the Trust Fund as is not, in the trustee's judg-
10 ment, required to meet current withdrawals. Such
11 investments may be made only in interest-bearing
12 obligations of the United States or in obligations
13 guaranteed as to both principal and interest by the
14 United States. For such purpose such obligations
15 may be acquired on original issue at the issue price,
16 or by purchase of outstanding obligations at market
17 price. The purposes for which obligations of the
18 United States may be issued under chapter 31 of
19 title 31, United States Code, are hereby extended to
20 authorize the issuance at par of public-debt obliga-
21 tions for purchase by the Trust Fund. Such obliga-
22 tions issued for purchase by the Trust Fund shall
23 have maturities fixed with due regard for the needs
24 of the Trust Fund and shall bear interest at a rate
25 equal to the average market yield (computed by the

1 Managing Trustee on the basis of market quotations
2 as of the end of the calendar month next preceding
3 the date of such issue) on all marketable interest-
4 bearing obligations of the United States then form-
5 ing a part of the public debt which are not due or
6 callable until after the expiration of 4 years from the
7 end of such calendar month, except that where such
8 average is not a multiple of $\frac{1}{8}$ of 1 percent, the rate
9 of interest on such obligations shall be the multiple
10 of $\frac{1}{8}$ of 1 percent nearest such market yield. The
11 Managing Trustee may purchase other interest-bear-
12 ing obligations of the United States or obligations
13 guaranteed as to both principal and interest by the
14 United States, on original issue or at the market
15 price, only where the Trustee determines that the
16 purchase of such other obligations is in the public
17 interest.

18 (3) Any obligations acquired by the Trust Fund
19 (except public-debt obligations issued exclusively to
20 the Trust Fund) may be sold by the Managing
21 Trustee at the market price, and such public-debt
22 obligations may be redeemed at par plus accrued in-
23 terest.

24 (4) The interest on, and the proceeds from the
25 sale or redemption of, any obligations held in the

1 Trust Fund shall be credited to and form a part of
2 the Trust Fund.

3 (5) The receipts and disbursements of the At-
4 torney General in the discharge of the functions of
5 the Attorney General shall not be included in the to-
6 tals of the budget of the United States Government.
7 For purposes of part C of the Balanced Budget and
8 Emergency Deficit Control Act of 1985, the Attor-
9 ney General and the Trust Fund shall be treated in
10 the same manner as the Federal Retirement Thrift
11 Investment Board and the Thrift Savings Fund, re-
12 spectively. The United States is not liable for any
13 obligation or liability incurred by the Trust Fund.

14 (c) USE OF FUNDS.—Of the amounts in the Trust
15 Fund—

16 (1) not less than 60 percent shall be used to
17 support educational activities to prevent the occur-
18 rence of violations of anti-fraud and abuse laws, in-
19 cluding the issuance of advisory opinions under sec-
20 tion 1129 and 1877(i) of the Social Security Act (as
21 added by part 4) and fraud alerts, seminars for pro-
22 viders, and program updates; and

23 (2) any amounts remaining after use for activi-
24 ties under paragraph (1) shall be used to assist the
25 Attorney General in carrying out the all-payor fraud

1 and abuse control program established under section
2 2301(a) in the fiscal year involved.

3 (d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD
4 AND ABUSE PENALTIES INTO TRUST FUND.—Section
5 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a–
6 7a(f)(3)) is amended by striking “as miscellaneous re-
7 cepts of the Treasury of the United States” and inserting
8 “in the Anti-Fraud and Abuse Trust Fund established
9 under section 2303(a) of the Affordable Health Care Now
10 Act of 1994”.

11 (e) USE OF FEDERAL HEALTH ANTI-FRAUD AND
12 ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-
13 SHARING.—Section 1128A(f) of the Social Security Act
14 (42 U.S.C. 1320a–7a(f)) is amended in the matter preced-
15 ing paragraph (1) by striking “Secretary and disposed of
16 as follows:” and inserting the following: “Secretary. If the
17 person against whom such a penalty or assessment was
18 assessed collected a payment from an individual for pro-
19 viding to the individual the service that is the subject of
20 the penalty or assessment, the Secretary shall pay a por-
21 tion of the amount recovered to the individual in the na-
22 ture of restitution in an amount equal to the payment so
23 collected. The Secretary shall dispose of any remaining
24 amounts recovered under this section as follows:”.

1 **PART 2—REVISIONS TO CURRENT SANCTIONS**
2 **FOR FRAUD AND ABUSE**

3 **SEC. 2311. MANDATORY EXCLUSION FROM PARTICIPATION**
4 **IN MEDICARE AND STATE HEALTH CARE PRO-**
5 **GRAMS.**

6 (a) INDIVIDUAL CONVICTED OF FELONY RELATING
7 TO FRAUD.—

8 (1) IN GENERAL.—Section 1128(a) of the So-
9 cial Security Act (42 U.S.C. 1320a-7(a)) is amend-
10 ed by adding at the end the following new para-
11 graph:

12 “(3) FELONY CONVICTION RELATING TO
13 FRAUD.—Any individual or entity that has been con-
14 victed, under Federal or State law, in connection
15 with the delivery of a health care item or service on
16 or after the date of the enactment of this paragraph,
17 or with respect to any act or omission on or after
18 such date in a program (other than those specifically
19 described in paragraph (1)) operated by or financed
20 in whole or in part by any Federal, State, or local
21 government agency, of a criminal offense consisting
22 of a felony relating to fraud, theft, embezzlement,
23 breach of fiduciary responsibility, or other financial
24 misconduct.”.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a-7(b)(1)) is amended—

(A) in the heading, by striking “CONVICTION” and inserting “MISDEMEANOR CONVICTION”; and

(B) by striking “criminal offense” and inserting “criminal offense consisting of a misdemeanor”.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

“(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.”.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a-7(b)(3)) is amended—

1 (A) in the heading, by striking “CONVIC-
2 TION” and inserting “MISDEMEANOR CONVIC-
3 TION”; and

4 (B) by striking “criminal offense” and in-
5 serting “criminal offense consisting of a mis-
6 demeanor”.

7 **SEC. 2312. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
8 **CLUSION FOR CERTAIN INDIVIDUALS AND**
9 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
10 **SION FROM MEDICARE AND STATE HEALTH**
11 **CARE PROGRAMS.**

12 Section 1128(c)(3) of the Social Security Act (42
13 U.S.C. 1320a-7(c)(3)) is amended by adding at the end
14 the following new subparagraphs:

15 “(D) In the case of an exclusion of an individual or
16 entity under paragraph (1), (2), or (3) of subsection (b),
17 the period of the exclusion shall be 3 years, unless the
18 Secretary determines in accordance with published regula-
19 tions that a shorter period is appropriate because of miti-
20 gating circumstances or that a longer period is appro-
21 priate because of aggravating circumstances.

22 “(E) In the case of an exclusion of an individual or
23 entity under subsection (b)(4) or (b)(5), the period of the
24 exclusion shall not be less than the period during which
25 the individual’s or entity’s license to provide health care

1 is revoked, suspended, or surrendered, or the individual
2 or the entity is excluded or suspended from a Federal or
3 State health care program.

4 “(F) In the case of an exclusion of an individual or
5 entity under subsection (b)(6)(B), the period of the exclu-
6 sion shall be not less than 1 year.”.

7 **SEC. 2313. REVISIONS TO CRIMINAL PENALTIES.**

8 (a) CLARIFICATION OF DISCOUNT EXCEPTION TO
9 ANTI-KICKBACK PROVISIONS.—Section 1128B(b)(3)(A)
10 of the Social Security Act (42 U.S.C. 1320a-7b(b)(3)(A))
11 is amended—

12 (1) by inserting “(regardless of its timing or
13 availability)” after “in price”; and

14 (2) by striking “program;” and inserting “pro-
15 gram and is not paid in the form of currency or
16 coin;”.

17 (b) EXEMPTION FROM ANTI-KICKBACK PENALTIES
18 FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section
19 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is
20 amended—

21 (1) by striking “and” at the end of subpara-
22 graph (D);

23 (2) by striking the period at the end of sub-
24 paragraph (E) and inserting “; and”; and

1 (3) by adding at the end the following new sub-
2 paragraph:

3 “(F) any reduction in cost sharing or increased
4 benefits given to an individual, any amounts paid to
5 a provider for an item or service furnished to an in-
6 dividual, or any discount or reduction in price given
7 by the provider for such an item or service, if—

8 “(A) the item or service is provided
9 through an organization described in section
10 1877(b)(3), or

11 “(B) the item or service is provided
12 through such an organization on behalf of an-
13 other entity (including but not limited to a self-
14 insured employer or indemnity plan) that as-
15 sumes financial risk for the provision of the
16 item or service.”.

17 (c) EXEMPTION FROM ANTI-KICKBACK PENALTIES
18 FOR CERTAIN PROTECTED FINANCIAL RELATIONSHIPS.—
19 Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-
20 7b(b)(3)), as amended by subsection (b), is further amend-
21 ed—

22 (1) by striking “and” at the end of subpara-
23 graph (E);

24 (2) by striking the period at the end of sub-
25 paragraph (F) and inserting “; and”; and

(3) by adding at the end the following new subparagraph:

“(G) any amount in a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in section 1877(a)(2), if section 1877(a)(1) does not apply to that amount or financial relationship.”.

SEC. 2315. REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

(a) CLARIFICATION OF COVERAGE OF RADIOLOGY OR DIAGNOSTIC SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraph (D).

(b) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—Section 1877(b) of such Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

“(4) SHARED FACILITY SERVICES.—

“(A) IN GENERAL.—In the case of a shared facility service of a shared facility—

“(i) that is furnished—

1 “(I) personally by the referring
2 physician who is a shared facility phy-
3 sician or personally by an individual
4 directly employed by such a physician,

5 “(II) by a shared facility in a
6 building in which the referring physi-
7 cian furnishes substantially all of the
8 services of the physician that are un-
9 related to the furnishing of shared fa-
10 cility services, and

11 “(III) to a patient of a shared fa-
12 cility physician; and

13 “(ii) that is billed by the referring
14 physician.

15 “(B) SHARED FACILITY RELATED DEFINI-
16 TIONS.—

17 “(i) SHARED FACILITY SERVICE.—

18 The term ‘shared facility service’ means,
19 with respect to a shared facility, a des-
20 ignated health service furnished by the fa-
21 cility to patients of shared facility physi-
22 cians.

23 “(ii) SHARED FACILITY.—The term
24 ‘shared facility’ means an entity that fur-

1 nishes shared facility services under a
2 shared facility arrangement.

3 “(iii) SHARED FACILITY PHYSICIAN.—

4 The term ‘shared facility physician’ means,
5 with respect to a shared facility, a physi-
6 cian who has a financial relationship under
7 a shared facility arrangement with the fa-
8 cility.

9 “(iv) SHARED FACILITY ARRANGE-

10 MENT.—The term ‘shared facility arrange-
11 ment’ means, with respect to the provision
12 of shared facility services in a building, a
13 financial arrangement—

14 “(I) which is only between physi-
15 cians who are providing services (un-
16 related to shared facility services) in
17 the same building,

18 “(II) in which the overhead ex-
19 penses of the facility are shared, in
20 accordance with methods previously
21 determined by the physicians in the
22 arrangement, among the physicians in
23 the arrangement, and

1 “(III) which, in the case of a cor-
2 poration, is wholly owned and con-
3 trolled by shared facility physicians.”.

4 (c) REVISION TO RURAL PROVIDER EXCEPTION.—
5 Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2))
6 is amended by striking “substantially all” and inserting
7 “not less than 75 percent (as determined in accordance
8 with regulations of the Secretary)”.

9 (d) CLARIFICATION OF REFERRALS BY
10 NEPHROLOGISTS.—Section 1877(h)(5)(C) of such Act (42
11 U.S.C. 1395nn(H)(5)(C)) is amended—

12 (1) by striking “and a request” and inserting
13 “a request”;

14 (2) by inserting after “radiation therapy,” the
15 following: “and a request by a nephrologist for items
16 or services related to renal dialysis,”; and

17 (3) by striking “or radiation oncologist” and in-
18 serting “radiation oncologist, or nephrologist”.

19 (e) REVISION OF REPORTING REQUIREMENTS.—Sec-
20 tion 1877(f) of such Act (42 U.S.C. 1395nn(f)) is amend-
21 ed—

22 (1) by striking “Each entity” and all that fol-
23 lows through paragraph (2) and inserting the follow-
24 ing: “The Secretary may require each entity (other
25 than a physician or physician group practice) provid-

ing designated health services to provide the Secretary with the following information concerning the entity's ownership, investment, and compensation arrangements:

“(1) the designated health services provided by the entity; and

“(2) the names and unique physician identifier numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)) or with a compensation interest (as described in subsection (a)(2)(B)) in the entity, or whose immediate relatives have such an ownership, investment, or compensation interest in the entity.”; and

(2) by striking the fifth sentence.

(f) EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) of such Act (42 U.S.C. 1395nn(b)(3)) is amended—

(1) by striking “or” at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting a comma; and

(3) by adding at the end the following new subparagraphs:

1 “(E) with a contract with a State to pro-
2 vide services under the State plan under title
3 XIX (in accordance with section 1903(m)); or

4 “(F) which meets State regulatory require-
5 ments applicable to health maintenance organi-
6 zations and which—

7 “(i) provides designated health serv-
8 ices directly or through contractual ar-
9 rangements with providers;

10 “(ii) assumes financial risk for the
11 provision of services or provides services on
12 behalf of another individual or entity (in-
13 cluding but not limited to a self-insured
14 employer, indemnity plan, physician, or
15 physician group) that assumes financial
16 risk for the provision of the item or serv-
17 ice; and

18 “(iii) subjects the services to a pro-
19 gram of utilization review offered by an or-
20 ganization described in a preceding sub-
21 paragraph, an organization meeting State
22 regulatory requirements applicable to utili-
23 zation review, or an organization accred-
24 ited to perform utilization review consid-
25 ered appropriate by the Secretary.”.

1 (g) PREEMPTION OF STATE LAW.—Section 1877(g)
2 of such Act (42 U.S.C. 1395nn(g)) is amended by adding
3 at the end the following new paragraph:

4 “(6) PREEMPTION OF STATE LAW.—The provi-
5 sions of this section shall supersede any State law to
6 the extent State law prohibits a physician from mak-
7 ing a referral, or an entity from presenting a bill, for
8 the furnishing of a service which is not subject to
9 the restrictions applicable under paragraph (1).”.

10 (h) REVISION OF EFFECTIVE DATE EXCEPTION PRO-
11 VISION.—Section 13562(b)(2) of the Omnibus Budget
12 Reconciliation Act of 1993 is amended by striking sub-
13 paragraphs (A) and (B) and inserting the following:

14 “(A) the second sentence of subsection
15 (a)(2), and subsections (b)(2)(B) and (d)(2), of
16 section 1877 of the Social Security Act (as in
17 effect on the day before the date of the enact-
18 ment of this Act) shall apply instead of the cor-
19 responding provisions in section 1877 (as
20 amended by this Act);

21 “(B) section 1877(b)(4) of the Social Se-
22 curity Act (as in effect on the day before the
23 date of the enactment of this Act) shall apply;

24 “(C) the requirements of section
25 1877(c)(2) of the Social Security Act (as

1 amended by this Act) shall not apply to any se-
2 curities of a corporation that meets the require-
3 ments of section 1877(c)(2) of the Social Secu-
4 rity Act (as in effect on the day before the date
5 of the enactment of this Act);

6 “(D) section 1877(e)(3) of the Social Secu-
7 rity Act (as amended by this Act) shall apply,
8 except that it shall not apply to any arrange-
9 ment that meets the requirements of subsection
10 (e)(2) or subsection (e)(3) of section 1877 of
11 the Social Security Act (as in effect on the day
12 before the date of the enactment of this Act);

13 “(E) the requirements of clauses (iv) and
14 (v) of section 1877(h)(4)(A), and of clause (i)
15 of section 1877(h)(4)(B), of the Social Security
16 Act (as amended by this Act) shall not apply;
17 and

18 “(F) section 1877(h)(4)(B) of the Social
19 Security Act (as in effect on the day before the
20 date of the enactment of this Act) shall apply
21 instead of section 1877(h)(4)(A)(ii) of such Act
22 (as amended by this Act).”.

23 (i) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to referrals made on or after Janu-
25 ary 1, 1995, except that the amendments made by sub-

1 section (h) shall apply as if included in the enactment of
2 the Omnibus Budget Reconciliation Act of 1993.

3 **SEC. 2316. MEDICARE HEALTH MAINTENANCE ORGANIZA-**
4 **TIONS.**

5 (a) **STUDY ON COSTS OF PEER REVIEW CONTRACTS**
6 **FOR MEDICARE HMOs.**—The Comptroller General shall
7 conduct a study of the costs incurred by eligible organiza-
8 tions with risk-sharing contracts under section 1876(b) of
9 the Social Security Act of complying with the requirement
10 of entering into a written agreement with an entity provid-
11 ing peer review services with respect to services provided
12 by the organization, together with an analysis of how in-
13 formation generated by such entities is used by the Sec-
14 retary of Health and Human Services to assess the quality
15 of services provided by such eligible organizations.

16 (b) **REPORT TO CONGRESS.**—Not later than July 1,
17 1997, the Comptroller General shall submit a report to
18 the Committee on Ways and Means and the Committee
19 on Energy and Commerce of the House of Representatives
20 and the Committee on Finance and the Special Committee
21 on Aging of the Senate on the study conducted under sub-
22 section (a).

23 **SEC. 2317. EFFECTIVE DATE.**

24 Except as otherwise provided, the amendments made
25 by this part shall take effect January 1, 1996.

PART 3—AMENDMENTS TO CRIMINAL LAW**SEC. 2321. PENALTIES FOR HEALTH CARE FRAUD.**

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

“§ 1347. Health care fraud

“(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

“(1) to defraud any health care plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

“(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be guilty of a felony, and fined under this title or imprisoned not more than 5 years, or both.

“(b) In determining the amount or scope of any penalty or assessment, the court shall take into account—

“(1) the nature of the false or fraudulent claims and the circumstances under which they are presented;

1 “(2) the degree of culpability and history of
2 prior offenses by the convicted health care provider;

3 “(3) the extent to which restitution is paid; and

4 “(4) such other matters as justice may require.

5 “(c) A principal is liable for penalties and assess-
6 ments under this section for the acts of the principal’s
7 agents acting within the scope of the agency.

8 “(d) For purposes of this section, the term ‘health
9 care plan’ means a Federally-funded public program or
10 private program for the delivery of or payment for health
11 care items or services.”.

12 (2) CLERICAL AMENDMENT.—The table of sec-
13 tions at the beginning of chapter 63 of title 18,
14 United States Code, is amended by adding at the
15 end the following:

“1347. Health care fraud.”.

16 **SEC. 2322. REWARDS FOR INFORMATION LEADING TO**
17 **PROSECUTION AND CONVICTION.**

18 Section 3059 of title 18, United States Code, is
19 amended by adding at the end the following new sub-
20 section:

21 “(c)(1) In special circumstances and in the Attorney
22 General’s sole discretion, the Attorney General may make
23 a payment of up to \$10,000 to a person who furnishes
24 information unknown to the Government relating to a pos-
25 sible prosecution under section 1347.

1 “(2) A person is not eligible for a payment under
2 paragraph (1) if—

3 “(A) the person is a current or former officer
4 or employee of a Federal or State government agen-
5 cy or instrumentality who furnishes information dis-
6 covered or gathered in the course of government em-
7 ployment;

8 “(B) the person knowingly participated in the
9 offense;

10 “(C) the information furnished by the person
11 consists of allegations or transactions that have been
12 disclosed to the public—

13 “(i) in a criminal, civil, or administrative
14 proceeding;

15 “(ii) in a congressional, administrative or
16 General Accounting Office report, hearing,
17 audit or investigation; or

18 “(iii) by the news media, unless the person
19 is the original source of the information; or

20 “(D) when, in the judgment of the Attorney
21 General, it appears that a person whose illegal ac-
22 tivities are being prosecuted or investigated could
23 benefit from the award.

24 “(3) For the purposes of paragraph (2)(C)(iii), the
25 term ‘original source’ means a person who has direct and

1 independent knowledge of the information that is fur-
2 nished and has voluntarily provided the information to the
3 Government prior to disclosure by the news media.

4 “(4) Neither the failure of the Attorney General to
5 authorize a payment under paragraph (1) nor the amount
6 authorized shall be subject to judicial review.”.

7 **SEC. 2323. BROADENING APPLICATION OF MAIL FRAUD**
8 **STATUTE.**

9 Section 1341 of title 18, United States Code, is
10 amended—

11 (1) by inserting “or deposits or causes to be de-
12 posited any matter or thing whatever to be sent or
13 delivered by any private or commercial interstate
14 carrier,” after “Postal Service,”; and

15 (2) by inserting “or such carrier” after “causes
16 to be delivered by mail”.

17 **PART 4—ADVISORY OPINIONS**

18 **SEC. 2331. AUTHORIZING THE SECRETARY OF HEALTH AND**
19 **HUMAN SERVICES TO ISSUE ADVISORY OPIN-**
20 **IONS UNDER TITLE XI.**

21 Title XI of the Social Security Act (42 U.S.C. 1301
22 et seq.) is amended by inserting after section 1128B the
23 following new section:

1 “ADVISORY OPINIONS

2 “SEC. 1129. (a) ISSUANCE OF ADVISORY OPIN-
3 IONS.—The Secretary shall issue advisory opinions as pro-
4 vided in this section.

5 “(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—
6 The Secretary shall issue advisory opinions as to the fol-
7 lowing matters:

8 “(1) What constitutes prohibited remuneration
9 within the meaning of section 1128B(b).

10 “(2) Whether an arrangement or proposed ar-
11 rangement satisfies the criteria set forth in section
12 1128B(b)(3) for activities which do not result in
13 prohibited remuneration.

14 “(3) Whether an arrangement or proposed ar-
15 rangement satisfies the criteria which the Secretary
16 has established, or shall establish by regulation for
17 activities which do not result in prohibited remu-
18 nation.

19 “(4) What constitutes an inducement to reduce
20 or limit services to individuals entitled to benefits
21 under title XVIII or title XIX within the meaning
22 of section 1128B(b).

23 “(5) Whether an arrangement, activity or pro-
24 posed arrangement or proposed activity violates any
25 other provision of this Act.

1 “(c) MATTERS NOT SUBJECT TO ADVISORY OPIN-
2 IONS.—Such advisory opinions shall not address the fol-
3 lowing matters:

4 “(1) Whether the fair market value shall be, or
5 was paid or received for any goods, services or prop-
6 erty.

7 “(2) Whether an individual is a bona fide em-
8 ployee within the requirements of section 3121(d)(2)
9 of the Internal Revenue Code of 1986.

10 “(d) EFFECT OF ADVISORY OPINIONS.—

11 “(1) Each advisory opinion issued by the Sec-
12 retary shall be binding as to the Secretary and the
13 party or parties requesting the opinion.

14 “(2) The failure of a party to seek an advisory
15 opinion may not be introduced into evidence to prove
16 that the party intended to violate the provisions of
17 sections 1128, 1128A, or 1128B.

18 “(e) REGULATIONS.—The Secretary within 180 days
19 of the date of enactment, shall issue regulations establish-
20 ing a system for the issuance of advisory opinions. Such
21 regulations shall provide for—

22 “(1) the procedure to be followed by a party ap-
23 plying for an advisory opinion;

1 “(2) the procedure to be followed by the Sec-
2 retary in responding to a request for an advisory
3 opinion;

4 “(3) the interval in which the Secretary shall
5 respond;

6 “(4) the reasonable fee to be charged to the
7 party requesting an advisory opinion; and

8 “(5) the manner in which advisory opinions will
9 be made available to the public.

10 “(f) INTERVAL FOR ISSUANCE OF ADVISORY OPIN-
11 IONS.—Under no circumstances shall the interval in which
12 the Secretary shall respond to a party requesting an advi-
13 sory opinion exceed 30 days.”.

14 **SEC. 2332. AUTHORIZING THE SECRETARY OF HEALTH AND**
15 **HUMAN SERVICES TO ISSUE ADVISORY OPIN-**
16 **IONS RELATING TO PHYSICIAN OWNERSHIP**
17 **AND REFERRAL.**

18 Section 1877 of the Social Security Act (42 U.S.C.
19 1395nn) is amended by the addition of the following new
20 subsection:

21 “(i) ADVISORY OPINIONS.—

22 “(1) IN GENERAL.—The Secretary shall issue
23 advisory opinions on whether an arrangement or
24 proposed arrangement will result in a prohibited re-
25 ferral within the meaning of this section.

1 “(2) EFFECT OF ADVISORY OPINIONS.—

2 “(A) Each advisory opinion issued by the
3 Secretary shall be binding as to the Secretary
4 and the party or parties requesting the opinion.

5 “(B) The failure of a party to seek an ad-
6 visory opinion may not be introduced into evi-
7 dence to prove that the party intended to vio-
8 late the provisions of this section.

9 “(3) REGULATIONS.—The Secretary within one
10 hundred and eighty days of the date of enactment,
11 shall issue regulations establishing a system for the
12 issuance of advisory opinions. Such regulations shall
13 provide for—

14 “(A) the procedure to be followed by a
15 party applying for an advisory opinion;

16 “(B) the procedure to be followed by the
17 Secretary in responding to a request for an ad-
18 visory opinion;

19 “(C) the interval in which the Secretary
20 shall respond;

21 “(D) the reasonable fee to be charged to
22 the party requesting an advisory opinion; and

23 “(E) the manner in which advisory opin-
24 ions will be made available to the public.

1 “(4) INTERVAL FOR ISSUANCE OF ADVISORY
2 OPINIONS.—Under no circumstances shall the inter-
3 val in which the Secretary shall respond to a party
4 requesting an advisory opinion exceed thirty days.”.

5 **SEC. 2333. EFFECTIVE DATE.**

6 Unless otherwise specified, the amendments made by
7 this part shall be effective upon the enactment of this Act.

8 **Subtitle E—Increased Medicare**
9 **Beneficiary Choice; Additional**
10 **Medicare Reforms**

11 **PART 1—INCREASED MEDICARE BENEFICIARY**
12 **CHOICE**

13 **SEC. 2401. REQUIREMENTS FOR HEALTH MAINTENANCE**
14 **ORGANIZATIONS UNDER MEDICARE.**

15 (a) USE OF METROPOLITAN STATISTICAL AREAS TO
16 DETERMINE ADJUSTED AVERAGE PER CAPITA COST.—
17 Section 1876(a)(4) of such Act (42 U.S.C.
18 1395mm(a)(4)) is amended by striking “in a geographic
19 area served by an eligible organization or in a similar
20 area” and inserting “in the metropolitan statistical area
21 (as defined by the Office of Management and Budget) in
22 which the individual resides, or in the entire portion of
23 the State in which the individual resides which is not lo-
24 cated in a metropolitan statistical area in the case of an

1 individual who does not reside in a metropolitan statistical
2 area”.

3 (b) DETERMINATION OF MODEL ADDITIONAL
4 HEALTH BENEFIT PACKAGES.—Section 1876(g) of such
5 Act (42 U.S.C. 1395mm(g)) is amended by inserting after
6 paragraph (3) the following new paragraph:

7 “(4) The Secretary shall develop the following model
8 packages of additional health benefits (referred to in para-
9 graph (3)(B)) which an eligible organization may provide
10 (at its option) under paragraph (2):

11 “(A) Coverage for catastrophic illness (subject
12 to a limit on out-of-pocket expenditures).

13 “(B) Coverage for prescription drugs.

14 “(C) Coverage for preventive services.”.

15 (c) REVISION OF MEMBERSHIP LIMITATION.—Sec-
16 tion 1876(f) of the Social Security Act (42 U.S.C.
17 1395mm(f)) is amended—

18 (1) in paragraph (1), by striking “one-half”
19 and inserting “25 percent”; and

20 (2) in paragraph (2)(A), by striking “50 per-
21 cent” and inserting “75 percent”.

22 (d) ENROLLMENT PERIODS FOR MEDICARE HEALTH
23 MAINTENANCE ORGANIZATIONS.—

24 (1) UNIFORM OPEN ENROLLMENT PERIOD.—

25 Section 1876(c)(3)(A)(i) of such Act (42 U.S.C.

1 1395mm(c)(3)(A)(i)) is amended by striking “must
 2 have” and all that follows through “and including”
 3 and inserting the following: “shall have open enroll-
 4 ment during an annual uniform open enrollment pe-
 5 riod established by the Secretary for all eligible orga-
 6 nizations, together with”.

7 (2) OPEN ENROLLMENT FOR CERTAIN
 8 DISENROLLED INDIVIDUALS.—Section
 9 1876(c)(3)(A)(ii)(I) of such Act (42 U.S.C.
 10 1395mm(c)(3)(A)(ii)(I)) is amended by adding at
 11 the end the following: “Each eligible organization
 12 with a risk-sharing contract under this section shall
 13 have an open enrollment period for individuals resid-
 14 ing in the organization’s service area who disenroll
 15 from another eligible organization with a risk-shar-
 16 ing contract under this section on the grounds that
 17 the individual’s primary care physician is no longer
 18 a member of the organization’s provider network or
 19 for cause (in accordance with such standards, and as
 20 demonstrated through an appeals process that meets
 21 such requirements, as the Secretary may establish).
 22 (e) EFFECTIVE DATE.—The amendments made by
 23 this section shall apply to contracts entered into on or
 24 after the date of the enactment of this Act.

1 **SEC. 2402. EXPANSION AND REVISION OF MEDICARE SE-**
2 **LECT POLICIES.**

3 (a) PERMITTING MEDICARE SELECT POLICIES IN
4 ALL STATES.—

5 (1) IN GENERAL.—Subsection (c) of section
6 4358 of the Omnibus Budget Reconciliation Act of
7 1990 (hereafter referred to as “OBRA-1990”) is
8 hereby repealed.

9 (2) CONFORMING AMENDMENT.—Section 4358
10 of OBRA-1990 is amended by redesignating sub-
11 section (d) as subsection (c).

12 (b) REQUIREMENTS OF MEDICARE SELECT POLI-
13 CIES.—Section 1882(t)(1) of the Social Security Act (42
14 U.S.C. 1395ss(t)(1)) is amended to read as follows:

15 “(1)(A) If a medicare supplemental policy meets the
16 1991 NAIC Model Regulation or 1991 Federal Regulation
17 and otherwise complies with the requirements of this sec-
18 tion except that—

19 “(i) the benefits under such policy are re-
20 stricted to items and services furnished by certain
21 entities (or reduced benefits are provided when items
22 or services are furnished by other entities), and

23 “(ii) in the case of a policy described in sub-
24 paragraph (C)(i)—

1 “(I) the benefits under such policy are not
2 one of the groups or packages of benefits de-
3 scribed in subsection (p)(2)(A),

4 “(II) except for nominal copayments im-
5 posed for services covered under part B of this
6 title, such benefits include at least the core
7 group of basic benefits described in subsection
8 (p)(2)(B), and

9 “(III) an enrollee’s liability under such pol-
10 icy for physician’s services covered under part
11 B of this title is limited to the nominal
12 copayments described in subclause (II),

13 the policy shall nevertheless be treated as meeting those
14 standards if the policy meets the requirements of subpara-
15 graph (B).

16 “(B) A policy meets the requirements of this sub-
17 paragraph if—

18 “(i) full benefits are provided for items and
19 services furnished through a network of entities
20 which have entered into contracts or agreements
21 with the issuer of the policy,

22 “(ii) full benefits are provided for items and
23 services furnished by other entities if the services are
24 medically necessary and immediately required be-
25 cause of an unforeseen illness, injury, or condition

1 and it is not reasonable given the circumstances to
2 obtain the services through the network,

3 “(iii) the network offers sufficient access,

4 “(iv) the issuer of the policy has arrangements
5 for an ongoing quality assurance program for items
6 and services furnished through the network,

7 “(v)(I) the issuer of the policy provides to each
8 enrollee at the time of enrollment an explanation
9 of—

10 “(aa) the restrictions on payment under
11 the policy for services furnished other than by
12 or through the network,

13 “(bb) out of area coverage under the pol-
14 icy,

15 “(cc) the policy’s coverage of emergency
16 services and urgently needed care, and

17 “(dd) the availability of a policy through
18 the entity that meets the 1991 Model NAIC
19 Regulation or 1991 Federal Regulation without
20 regard to this subsection and the premium
21 charged for such policy, and

22 “(II) each enrollee prior to enrollment acknowl-
23 edges receipt of the explanation provided under
24 subclause (I), and

1 “(vi) the issuer of the policy makes available to
2 individuals, in addition to the policy described in this
3 subsection, any policy (otherwise offered by the is-
4 suer to individuals in the State) that meets the 1991
5 Model NAIC Regulation or 1991 Federal Regulation
6 and other requirements of this section without re-
7 gard to this subsection.

8 “(C)(i) A policy described in this subparagraph—

9 “(I) is offered by an eligible organization (as
10 defined in section 1876(b)),

11 “(II) is not a policy or plan providing benefits
12 pursuant to a contract under section 1876 or an ap-
13 proved demonstration project described in section
14 603(c) of the Social Security Amendments of 1983,
15 section 2355 of the Deficit Reduction Act of 1984,
16 or section 9412(b) of the Omnibus Budget Reconcili-
17 ation Act of 1986, and

18 “(III) provides benefits which, when combined
19 with benefits which are available under this title, are
20 substantially similar to benefits under policies of-
21 fered to individuals who are not entitled to benefits
22 under this title.

23 “(ii) In making a determination under subclause (III)
24 of clause (i) as to whether certain benefits are substan-
25 tially similar, there shall not be taken into account, except

1 in the case of preventive services, benefits provided under
2 policies offered to individuals who are not entitled to bene-
3 fits under this title which are in addition to the benefits
4 covered by this title and which are benefits an entity must
5 provide in order to meet the definition of an eligible orga-
6 nization under section 1876(b)(1).”.

7 (c) RENEWABILITY OF MEDICARE SELECT POLI-
8 CIES.—Section 1882(q)(1) of the Social Security Act (42
9 U.S.C. 1395ss(q)(1)) is amended—

10 (1) by striking “(1) Each” and inserting
11 “(1)(A) Except as provided in subparagraph (B),
12 each”;

13 (2) by redesignating subparagraphs (A) and
14 (B) as clauses (i) and (ii), respectively; and

15 (3) by adding at the end the following new sub-
16 paragraph:

17 “(B)(i) Except as provided in clause (ii), in the
18 case of a policy that meets the requirements of sub-
19 section (t), an issuer may cancel or nonrenew such
20 policy with respect to an individual who leaves the
21 service area of such policy.

22 “(ii) If an individual described in clause (i)
23 moves to a geographic area where an issuer de-
24 scribed in clause (i), or where an affiliate of such is-
25 suer, is issuing medicare supplemental policies, such

1 individual must be permitted to enroll in any medi-
 2 care supplemental policy offered by such issuer or
 3 affiliate that provides benefits comparable to or less
 4 than the benefits provided in the policy being can-
 5 celed or nonrenewed. An individual whose coverage
 6 is canceled or nonrenewed under this subparagraph
 7 shall, as part of the notice of termination or
 8 nonrenewal, be notified of the right to enroll in other
 9 medicare supplemental policies offered by the issuer
 10 or its affiliates.

11 “(iii) For purposes of this subparagraph, the
 12 term ‘affiliate’ shall have the meaning given such
 13 term by the 1991 NAIC Model Regulation.”.

14 (d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of
 15 the Social Security Act (42 U.S.C. 1395ss(t)(2)) is
 16 amended—

17 (1) by striking “(2)” and inserting “(2)(A)”;

18 (2) by redesignating subparagraphs (A), (B),
 19 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-
 20 spectively;

21 (3) in clause (iv), as so redesignated—

22 (A) by striking “paragraph (1)(E)(i)” and
 23 inserting “paragraph (1)(B)(v)(I), and

24 (B) by striking “paragraph (1)(E)(ii)” and
 25 inserting “paragraph (1)(B)(v)(II)”;

(4) by striking “the previous sentence” and inserting “this subparagraph”; and

(5) by adding at the end the following new subparagraph:

“(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed \$100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”.

(e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the “NAIC”) makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall

1 be applied in each State, effective for policies issued
2 to policyholders on and after the date specified in
3 paragraph (3), as if the reference to the Model Reg-
4 ulation adopted on June 6, 1979, were a reference
5 to the 1991 NAIC Model Regulation (as so defined)
6 as changed under this paragraph (such changed
7 Regulation referred to in this subsection as the
8 “1994 NAIC Model Regulation”).

9 (2) SECRETARY STANDARDS.—If the NAIC
10 does not make changes in the 1991 NAIC Model
11 Regulation (as so defined) within the 6-month period
12 specified in paragraph (1), the Secretary of Health
13 and Human Services (in this subsection as the “Sec-
14 retary”) shall promulgate a regulation and section
15 1882(g)(2)(A) of the Social Security Act shall be ap-
16 plied in each State, effective for policies issued to
17 policyholders on and after the date specified in para-
18 graph (3), as if the reference to the Model Regula-
19 tion adopted in June 6, 1979, were a reference to
20 the 1991 NAIC Model Regulation (as so defined) as
21 changed by the Secretary under this paragraph
22 (such changed Regulation referred to in this sub-
23 section as the “1994 Federal Regulation”).

24 (3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after Janu-

1 ary 1, 1995. For purposes of the previous sen-
2 tence, in the case of a State that has a 2-year
3 legislative session, each year of such session
4 shall be deemed to be a separate regular session
5 of the State legislature.

6 **SEC. 2403. INCLUDING NOTICE OF AVAILABLE HEALTH**
7 **MAINTENANCE ORGANIZATIONS IN ANNUAL**
8 **NOTICE TO BENEFICIARIES.**

9 Section 1804 of the Social Security Act (42 U.S.C.
10 1395b-2) is amended—

11 (1) by striking “and” at the end of paragraph
12 (2);

13 (2) by striking the period at the end of para-
14 graph (3) and inserting “, and”; and

15 (3) by inserting after paragraph (3) the follow-
16 ing new paragraph:

17 “(4) with respect to the area in which the indi-
18 vidual receiving the notice resides, a description of
19 the eligible organizations under section 1833(a)(1)
20 or section 1876 and the carriers offering a medicare
21 supplemental policy described in section 1882(t)(1)
22 which serve the area in which the individual receiv-
23 ing the notice resides.”.

SEC. 2404. LEGISLATIVE PROPOSAL ON ENROLLING MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a proposal for legislation which provides for the enrollment of medicare beneficiaries in private health insurance plans (including medicaid coverage described in section 1102(e)).

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term “medicare beneficiary” means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to private health insurance plans for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled in such a plan without an interruption in coverage upon becoming medicare beneficiaries; and

1 (3) provide medicare beneficiaries with the op-
2 portunity to enroll in a private health insurance
3 plan.

4 **SEC. 2405. OPTIONAL INTERIM ENROLLMENT OF MEDICARE**
5 **BENEFICIARIES IN PRIVATE HEALTH PLANS.**

6 (a) INTERIM ENROLLMENT OF MEDICARE BENE-
7 FICIARIES IN QUALIFIED HEALTH PLANS.—

8 (1) IN GENERAL.—Notwithstanding title XVIII
9 of the Social Security Act, the Secretary shall pro-
10 vide for a monthly payment as provided under sub-
11 section (b)(1) to a private health insurance plan on
12 behalf of enrolled medicare beneficiaries who choose
13 to enroll in such a plan.

14 (2) MEDICARE BENEFICIARY.—For purposes of
15 this section, the term “medicare beneficiary” means
16 an individual who is eligible for benefits under part
17 A of title XVIII of the Social Security Act and is en-
18 rolled under part B of such title.

19 (b) PAYMENT SPECIFIED.—

20 (1) FEDERAL PAYMENT.—

21 (A) IN GENERAL.—The amount of pay-
22 ment specified in this paragraph for an individ-
23 ual who is enrolled in a private health insurance
24 plan is the lesser of—

1 (i) the applicable rate specified in sec-
2 tion 1876(a)(1)(C) of the Social Security
3 Act (but at 100 percent, rather than 95
4 percent, of the applicable amount); or

5 (ii) the monthly premium charged the
6 individual for coverage under the private
7 health insurance plan.

8 (B) SOURCE OF PAYMENT.—The payment
9 to a private health insurance plan under this
10 paragraph for individuals entitled to benefits
11 under part A and enrolled under part B of title
12 XVIII of the Social Security Act shall be made
13 from the Federal Hospital Insurance Trust
14 Fund and the Federal Supplementary Medical
15 Insurance Trust Fund, with the allocation to be
16 determined by the Secretary.

17 (2) INDIVIDUAL'S SHARE.—If the monthly pre-
18 mium for the private plan in which the individual is
19 enrolled is greater than the amount specified under
20 paragraph (1)(A)(i), the individual shall be respon-
21 sible for paying to the plan the difference between
22 the monthly premium charged the individual for cov-
23 erage under the plan and the amount specified in
24 paragraph (1)(A)(i).

1 (c) PAYMENTS UNDER THIS SECTION AS SOLE MEDI-
2 CARE BENEFITS.—Payments made under this section
3 shall be instead of the amounts that would otherwise be
4 payable, pursuant to sections 1814(b) and 1833(a) of the
5 Social Security Act, for services furnished to medicare
6 beneficiaries.

7 (d) INCLUSION IN ANNUAL NOTICE TO BENE-
8 FICIARIES.—Section 1804 of the Social Security Act (42
9 U.S.C. (42 U.S.C. 1395b–2), as amended by section 2403,
10 is amended—

11 (1) by striking “and” at the end of paragraph
12 (3);

13 (2) by striking the period at the end of para-
14 graph (4) and inserting “, and”; and

15 (3) by inserting after paragraph (4) the follow-
16 ing new paragraph:

17 “(5) a description of the option provided pursu-
18 ant to section 2405 of the Affordable Health Care
19 Now Act of 1994 for payment to be made by the
20 Secretary on the individual’s behalf for enrollment in
21 a private health insurance plan.”.

1 **PART 2—MEDICARE PART B PREMIUM; OTHER**
 2 **MEDICARE PAYMENT CHANGES**

3 **SEC. 2411. EXTENSION OF CURRENT RULES FOR COMPUT-**
 4 **ING MEDICARE PART B PREMIUM.**

5 Section 1839(e) of the Social Security Act (42 U.S.C.
 6 1395r(e)) is amended—

7 (1) in paragraph (1)(A), by striking “January
 8 1999” and inserting “January 2005”; and

9 (2) in paragraph (2), by striking “January
 10 1998” and inserting “January 2004”.

11 **SEC. 2412. INCREASE IN MEDICARE PART B PREMIUM FOR**
 12 **INDIVIDUALS WITH HIGH INCOME.**

13 (a) IN GENERAL.—Subchapter A of chapter 1 of the
 14 Internal Revenue Code of 1986 is amended by adding at
 15 the end thereof the following new part:

16 **“PART VIII—MEDICARE PART B PREMIUMS FOR**
 17 **HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Medicare part B premium tax.

18 **“SEC. 59B. MEDICARE PART B PREMIUM TAX.**

19 “(a) IMPOSITION OF TAX.—In the case of an individ-
 20 ual to whom this section applies for the taxable year, there
 21 is hereby imposed (in addition to any other tax imposed
 22 by this subtitle) a tax for such taxable year equal to the
 23 aggregate of the Medicare part B premium taxes for each
 24 of the months during such year that such individual is
 25 covered by Medicare part B.

1 “(b) INDIVIDUALS TO WHOM SECTION APPLIES.—

2 This section shall apply to any individual for any taxable
3 year if—

4 “(1) such individual is covered under Medicare
5 part B for any month during such year, and

6 “(2) the modified adjusted gross income of the
7 taxpayer for such taxable year exceeds the threshold
8 amount.

9 “(c) MEDICARE PART B PREMIUM TAX FOR
10 MONTH.—

11 “(1) IN GENERAL.—The Medicare part B pre-
12 mium tax for any month is $\frac{2}{3}$ the amount equal to
13 the excess of—

14 “(A) 150 percent of the monthly actuarial
15 rate for enrollees age 65 and over determined
16 for that calendar year under section 1839(b) of
17 the Social Security Act, over

18 “(B) the total monthly premium under sec-
19 tion 1839 of the Social Security Act (deter-
20 mined without regard to subsections (b) and (f)
21 of section 1839 of such Act).

22 “(2) PHASEIN OF TAX.—If the modified ad-
23 justed gross income of the taxpayer for any taxable
24 years exceeds the threshold amount by less than
25 \$50,000, the Medicare part B premium tax for any

month during such taxable year shall be an amount which bears the same ratio to the amount determined under paragraph (1) (without regard to this paragraph) as such excess bears to \$50,000. The preceding sentence shall not apply to any individual whose threshold amount is zero.

“(d) OTHER DEFINITIONS AND SPECIAL RULES.—

For purposes of this section—

“(1) THRESHOLD AMOUNT.—The term ‘threshold amount’ means—

“(A) except as otherwise provided in this paragraph, \$100,000,

“(B) \$125,000 in the case of a joint return, and

“(C) zero in the case of a taxpayer who—

“(i) is married at the close of the taxable year but does not file a joint return for such year, and

“(ii) does not live apart from his spouse at all times during the taxable year.

“(2) MODIFIED ADJUSTED GROSS INCOME.—

The term ‘modified adjusted gross income’ means adjusted gross income—

“(A) determined without regard to sections 135, 911, 931, and 933, and

“(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

“(3) MEDICARE PART B COVERAGE.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part for the month.

“(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703.”

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

“Part VIII. Medicare Part B Premiums For High-Income Individuals.”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months after December 1994 in taxable years ending after December 31, 1994.

SEC. 2413. IMPROVED EFFICIENCY THROUGH CONSOLIDATION OF ADMINISTRATION OF PARTS A AND B.

(a) IN GENERAL.—The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing

1 systems) of parts A and B of the medicare program (under
2 title XVIII of the Social Security Act) including over a
3 5-year period.

4 (b) COMBINATION OF INTERMEDIARY AND CARRIER
5 FUNCTIONS.—In taking such steps, the Secretary shall
6 contract with a single entity that combines the fiscal
7 intermediary and carrier functions in each area except
8 where the Secretary finds that special regional or national
9 contracts are appropriate.

10 (c) SUPERSEDING CONFLICTING REQUIREMENTS.—
11 The provisions of sections 1816 and 1842 of the Social
12 Security Act (including provider nominating provisions in
13 such section 1816) are superseded to the extent required
14 to carry out this section.

15 **SEC. 2414. EXTENSION OF MEDICARE SECONDARY PAY-**
16 **MENT PROVISIONS.**

17 (a) EXTENSION OF DATA MATCH.—

18 (1) Section 1862(b)(5)(C)(iii) of the Social Se-
19 curity Act (42 U.S.C. 1395y(b)(5)(C)(iii)) is amend-
20 ed by striking “1998” and inserting “2004”.

21 (2) Section 6103(l)(12)(F) of the Internal Rev-
22 enue Code of 1986 is amended—

23 (A) in clause (i), by striking “1998” and
24 inserting “2004”,

1 (B) in clause (ii)(I), by striking “1997”
 2 and inserting “2003”, and

3 (C) in clause (ii)(II), by striking “1998”
 4 and inserting “2004”.

5 (b) EXTENSION OF MEDICARE SECONDARY PAYER
 6 TO DISABLED BENEFICIARIES.—Section
 7 1862(b)(1)(B)(iii) of such Act (42 U.S.C.
 8 1395y(b)(1)(B)(iii)) is amended by striking “1998” and
 9 inserting “2004”.

10 (c) EXTENSION OF PERIOD FOR END STAGE RENAL
 11 DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) of such
 12 Act (42 U.S.C. 1395y(b)(1)(C)) is amended in the second
 13 sentence by striking “1998” and inserting “2004”.

14 **Subtitle F—Health Care Antitrust** 15 **Improvements**

16 **SEC. 2501. PROTECTION FROM ANTITRUST LAWS FOR CER-** 17 **TAIN COMPETITIVE AND COLLABORATIVE** 18 **ACTIVITIES.**

19 (a) PROTECTIONS DESCRIBED.—An activity relating
 20 to the provision of health care services shall receive the
 21 following protection from the antitrust laws:

22 (1) If the activity is within a safe harbor des-
 23 ignated by the Attorney General under section 2502,
 24 the safe harbor shall be a defense to all antitrust
 25 claims, except for claims for injunctive relief as-

1 serted by the Attorney General or the Chair of the
2 Federal Trade Commission in extraordinary cir-
3 cumstances.

4 (2) If the activity is specified in and in compli-
5 ance with the terms of a certificate of review issued
6 by the Attorney General under section 2503 and the
7 activity occurs while the certificate is in effect, the
8 certificate shall be a defense to antitrust claims,
9 other than claims for injunctive relief.

10 (b) AWARD OF ATTORNEY'S FEES AND COSTS OF
11 SUIT.—

12 (1) IN GENERAL.—If any person brings an ac-
13 tion alleging a claim under the antitrust laws and
14 the activity on which the claim is based is found by
15 the court to be protected from such laws under sub-
16 section (a), the court shall, at the conclusion of the
17 action—

18 (A) award to a substantially prevailing
19 claimant the cost of suit attributable to such
20 claim, including a reasonable attorney's fee, or

21 (B) award to a substantially prevailing
22 party defending against such claim the cost of
23 such suit attributable to such claim, including
24 reasonable attorney's fee, if the claim, or the
25 claimant's conduct during litigation of the

claim, was frivolous, unreasonable, without foundation, or in bad faith.

(2) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to paragraph (1) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

SEC. 2502. DESIGNATION OF SAFE HARBORS.

(a) IN GENERAL.—

(1) DESIGNATION BY ATTORNEY GENERAL.—

The Attorney General, in consultation with the Secretary of Health and Human Services and the Chair, shall develop and designate pursuant to paragraph (C) safe harbors for purposes of section 2501(a)(1) relating to—

(A) each category of activities referred to in paragraph (2); and

(B) such other categories of activities as the Attorney General may designate in accordance with the process described in this section.

1 (2) REQUIRED CATEGORIES OF ACTIVITIES SUB-
2 JECT TO SAFE HARBORS.—The categories of activi-
3 ties referred to in this paragraph are as follows:

4 (A) JOINT PURCHASING OF HEALTH CARE
5 SERVICES.—Providing the terms under which
6 consumers of health care services (patients or
7 others acting on their behalf) may jointly nego-
8 tiate and purchase health care services.

9 (B) SMALL HOSPITAL MERGERS.—Provid-
10 ing for small hospitals lawfully to merge under
11 the antitrust laws without undue delay or re-
12 view, taking into account the special needs and
13 circumstances of rural health care markets.

14 (C) NETWORK FORMATION AND OPER-
15 ATION.—Permitting activities related to the
16 startup and operation of collaborations between
17 State-licensed providers through partial or full
18 integration, including multi-provider networks,
19 hospital networks, physician-hospital organiza-
20 tions, and other efforts to provide health care
21 services more efficiently.

22 (D) ACTIVITIES OF MEDICAL SELF-REGU-
23 LATORY ENTITIES.—Permitting standard set-
24 ting and enforcement activities by medical self-
25 regulatory entities (such as hospital boards and

1 medical societies) to promote health care qual-
2 ity, except that a safe harbor under this para-
3 graph may not provide protection for any activ-
4 ity undertaken for financial gain or for anti-
5 competitive reasons.

6 (E) PROVISION OF INFORMATION TO BUY-
7 ERS AND CONSUMERS.—Permitting health care
8 providers collectively to supply non-price medi-
9 cal information to buyers and consumers relat-
10 ing to the type, quality and efficiency of treat-
11 ment, including joint views on procedures that
12 should be covered by purchasers and medical
13 protocols, except that a safe harbor under this
14 subparagraph may not provide protection for
15 any collective refusals to deal or collective at-
16 tempts at coercion.

17 (F) PARTICIPATION IN SURVEYS.—Provid-
18 ing the terms under which health care providers
19 may lawfully participate in written surveys of
20 prices of services, reimbursements received, em-
21 ployee compensation, and other relevant areas.

22 (G) HIGH-TECHNOLOGY AND TERTIARY
23 CARE JOINT VENTURES.—Permitting activities
24 of health care joint ventures to purchase or use
25 new or existing high technology or costly equip-

1 ment, or to provide advanced tertiary care serv-
2 ices.

3 (H) MARKET POWER SCREENS.—Providing
4 market power screens at appropriate levels
5 below which combinations of health care provid-
6 ers are too small to pose a realistic antitrust
7 threat. There may be different levels for dif-
8 ferent activities and markets, taking into ac-
9 count the special needs of rural health care
10 markets.

11 (I) JOINT PURCHASING ARRANGEMENTS.—
12 Providing the terms under which health care
13 providers may make joint purchases of products
14 and services.

15 (J) GOOD FAITH NEGOTIATIONS.—Provid-
16 ing the terms under which health care providers
17 may engage in discussions relating to legitimate
18 collaborative activities contemplated by the safe
19 harbors.

20 (b) PROCESS FOR DESIGNATION OF ADDITIONAL
21 CATEGORIES OF ACTIVITIES.—

22 (1) SOLICITATION OF PROPOSALS —Not later
23 than 30 days after the date of the enactment of this
24 Act, the Attorney General shall publish a notice in

1 the Federal Register soliciting proposals for safe
2 harbors.

3 (2) REVIEW OF PROPOSED SAFE HARBORS.—

4 Not later than 180 days after the date of the enact-
5 ment of this Act, the Attorney General (in consulta-
6 tion with the Secretary and the Chair) shall review
7 the proposed safe harbors submitted under para-
8 graph (1) and include a description of the safe har-
9 bors in the report under subsection (d).

10 (3) ADDITIONAL SAFE HARBORS.—After sub-

11 mitting the report under subsection (d), the Attor-
12 ney General (in consultation with the Secretary and
13 the Chair) may from time to time add additional
14 safe harbors in accordance with the procedures de-
15 scribed in this subsection.

16 (c) EFFECTIVE DATE OF SAFE HARBORS.—

17 (1) PUBLICATION.—Not later than 180 days

18 after the date of the enactment of this Act, the At-
19 torney General shall publish in the Federal Register
20 for public comment the safe harbors proposed for
21 designation under this section. Not later than 180
22 days after publishing such proposed safe harbors in
23 the Federal Register, the Attorney General shall
24 issue final rules establishing such safe harbors.

1 (2) EFFECTIVE DATE.—The safe harbors estab-
2 lished under the final rules issued under paragraph
3 (1) shall take effect 90 days after issuance, unless
4 disapproved by the Congress.

5 (d) REPORT ON PROPOSED SAFE HARBORS.—Not
6 later than 180 days after the date of the enactment of
7 this Act, the Attorney General (in consultation with the
8 Secretary and the Chair) shall submit a report to Congress
9 describing the proposals from subsections (a) and (b)(1)
10 to be included in the publication of safe harbors described
11 in subsection (c)(1) and the proposals from subsection
12 (b)(1) that are not to be so included, together with expla-
13 nations therefor.

14 (e) MODIFICATION OR REMOVAL OF SAFE HAR-
15 BORS.—The Attorney General (in consultation with the
16 Secretary and the Chair) may modify or remove a safe
17 harbor following notice and comment upon a determina-
18 tion that the safe harbor does not meet the criteria of sub-
19 section (f).

20 (f) CRITERIA FOR SAFE HARBORS.—In establishing
21 safe harbors under this section, the Attorney General shall
22 take into account the following:

23 (1) The extent to which a competitive or col-
24 laborative activity will accomplish any of the follow-
25 ing:

1 (A) An increase in access to health care
2 services.

3 (B) The enhancement of the quality of
4 health care services.

5 (C) The establishment of cost efficiencies
6 that will be passed on to consumers, including
7 economies of scale and reduced transaction and
8 administrative costs.

9 (D) An increase in the ability of health
10 care facilities to provide services in medically
11 underserved areas or to medically underserved
12 populations.

13 (E) An improvement in the utilization of
14 health care resources or the reduction in the in-
15 efficient duplication of the use of such re-
16 sources.

17 (2) Whether the designation of an activity as a
18 safe harbor will result in the following outcomes:

19 (A) Health plans and other health care in-
20 surers, consumers of health care services, and
21 health care providers will be better able to ne-
22 gotiate payment and service arrangements
23 which will reduce costs to consumers.

24 (B) Taking into consideration the charac-
25 teristics of the particular purchasers and pro-

1 viders involved, competition will not be unduly
2 restricted.

3 (C) Equally efficient and less restrictive al-
4 ternatives do not exist to meet the criteria de-
5 scribed in paragraph (1).

6 (D) The activity will not unreasonably
7 foreclose competition by denying competitors a
8 necessary element of competition.

9 **SEC. 2503. CERTIFICATES OF REVIEW.**

10 (a) ESTABLISHMENT OF PROGRAM.—In consultation
11 with the Secretary, the Attorney General shall (not later
12 than 180 days after the date of the enactment of this Act)
13 issue certificates of review in accordance with this section
14 for providers of health care services and advise and assist
15 any person with respect to applying for such a certificate
16 of review.

17 (b) PROCEDURES FOR APPLICATION FOR CERTIFI-
18 CATE.—

19 (1) SUBMISSION OF APPLICATION.—

20 (A) FORM; CONTENT.—To apply for a cer-
21 tificate of review, a person shall submit to the
22 Attorney General a written application which—

23 (i) specifies the activities relating to
24 the provision of health care services which
25 satisfy the criteria described in section

2502(e) and which will be included in the certificate; and

(ii) is in a form and contains any information, including information pertaining to the overall market in which the applicant operates, required by rule or regulation promulgated under section 2506.

(B) FILING FEE.—The Attorney General may require a filing fee to be submitted with the application to cover the cost of publication and the cost of review required by this section. The amount of the filing fee shall be determined on a sliding scale established by the Attorney General (based on the monetary size of the transaction involved), except that such fee may not exceed \$5,000.

(2) PUBLICATION OF NOTICE IN FEDERAL REGISTER.—Within 10 days after an application submitted under paragraph (1) is received by the Attorney General, the Attorney General shall publish in the Federal Register a notice that announces that an application for a certificate of review has been submitted, identifies each person submitting the application, and describes the conduct for which the application is submitted.

(3) ESTABLISHMENT OF PROCEDURES FOR ISSUANCE OF CERTIFICATE.—In consultation with the Chair and the Secretary, the Attorney General shall establish procedures to be used in applying for and in determining whether to approve an application for a certificate of review under this title. Under such procedures the Attorney General, in consultation with the Secretary, shall approve an application if the Attorney General determines that the activities to be covered under the certificate will satisfy the criteria described in section 2502(f) for safe harbors designated under such section and that the benefits of the issuance of the certificate will outweigh any disadvantages that may result from reduced competition. If the Attorney General, with the concurrence of the Secretary, determines that the requirements for a certificate are met, the Attorney General shall issue to the applicant a certificate of review. The certificate of review shall specify—

(i) the health care market activities to which the certificate applies,

(ii) the person to whom the certificate of review is issued, and

(iii) any terms and conditions the Attorney General or the Secretary deems nec-

1 essary to assure compliance with the appli-
2 cable procedures described in paragraph
3 (3).

4 (4) TIMING FOR DECISION ON APPLICATION.—

5 Within 90 days after the Attorney General receives
6 an application for a certificate of review, the Attor-
7 ney General shall determine whether to grant or
8 deny the certificate.

9 (5) NOTIFICATION OF DECISION.—The Attor-
10 ney General shall notify the applicant of the Attor-
11 ney General's determination and if the application is
12 denied, the reasons for the denial.

13 (6) FRAUDULENT PROCUREMENT.—A certifi-
14 cate of review shall be void ab initio with respect to
15 any health care market activities for which the cer-
16 tificate was procured by fraud.

17 (c) AMENDMENT AND REVOCATION OF CERTIFI-
18 CATES.—

19 (1) NOTIFICATION OF CHANGES.—Any appli-
20 cant who receives a certificate of review—

21 (A) shall promptly report to the Attorney
22 General any change relevant to the matters
23 specified in the certificate; and

24 (B) may submit to the Attorney General
25 an application to amend the certificate to re-

1 flect the effect of the change on the conduct
2 specified in the certificate.

3 (2) AMENDMENT TO CERTIFICATE.—An appli-
4 cation for an amendment to a certificate of review
5 shall be treated as an application for the issuance of
6 a certificate. The effective date of an amendment
7 shall be the date on which the application for the
8 amendment is received by the Attorney General.

9 (3) REVOCATION.—

10 (A) GROUNDS FOR REVOCATION.—In ac-
11 cordance with this paragraph, the Attorney
12 General, in consultation with the Secretary,
13 may revoke in whole or in part a certificate of
14 review issued under this section. There shall be
15 considered as grounds for the revocation of a
16 certificate the fact that—

17 (i) after the expiration of the 2-year
18 period beginning on the date a person's
19 certificate is issued, the activities of the
20 person have not substantially accomplished
21 the purposes for the issuance of the certifi-
22 cate;

23 (ii) the person has failed to comply
24 with any of the terms or conditions im-
25 posed under the certificate by the Attorney

1 General or the Secretary under subsection
2 (b)(4); or

3 (iii) the activities covered under the
4 certificate no longer satisfy the criteria set
5 forth in section 2502(f).

6 (B) REQUEST FOR COMPLIANCE INFORMA-
7 TION.—If the Attorney General or the Sec-
8 retary has reason to believe that any of the
9 grounds for revocation of a certificate of review
10 described in subparagraph (A) may apply to a
11 person holding the certificate, the Attorney
12 General shall request such information from
13 such person as the Attorney General or the Sec-
14 retary deems necessary to resolve the matter of
15 compliance. Failure to comply with such request
16 shall be grounds for revocation of the certificate
17 under this paragraph.

18 (C) PROCEDURES FOR REVOCATION.—If
19 the Attorney General or the Secretary deter-
20 mines that any of the grounds for revocation of
21 a certificate of review described in subpara-
22 graph (A) apply to a person holding the certifi-
23 cate, or that such person has failed to comply
24 with a request made under subparagraph (B),
25 the Attorney General shall give written notice of

1 the determination to such person. The notice
2 shall include a statement of the circumstances
3 underlying, and the reasons in support of, the
4 determination. In the 60-day period beginning
5 30 days after the notice is given, the Attorney
6 General shall revoke the certificate or modify it
7 as the Attorney General or the Secretary deems
8 necessary to cause the certificate to apply only
9 to activities that meet the criteria set forth in
10 section 2502(f).

11 (D) INVESTIGATION AUTHORITY.—For
12 purposes of carrying out this paragraph, the
13 Attorney General may conduct investigations in
14 the same manner as the Attorney General con-
15 ducts investigations under section 3 of the Anti-
16 trust Civil Process Act, except that no civil in-
17 vestigative demand may be issued to a person
18 to whom a certificate of review is issued if such
19 person is the target of such investigation.

20 (d) REVIEW OF DETERMINATIONS.—

21 (1) AVAILABILITY OF REVIEW FOR CERTAIN AC-
22 TIONS.—If the Attorney General denies, in whole or
23 in part, an application for a certificate of review or
24 for an amendment to a certificate, or revokes or
25 modifies a certificate pursuant to paragraph (3), the

1 applicant or certificate holder (as the case may be)
2 may, within 30 days of the denial or revocation,
3 bring an action in the United States District Court
4 for the District of Columbia to set aside the deter-
5 mination on the ground that such determination is
6 clearly erroneous.

7 (2) NO OTHER REVIEW PERMITTED.—Except
8 as provided in paragraph (1), no action by the At-
9 torney General, the Chair, or the Secretary pursuant
10 to this subtitle shall be subject to judicial review.

11 (3) EFFECT OF REJECTED APPLICATION.—If
12 the Attorney General denies, in whole or in part, an
13 application for a certificate of review or for an
14 amendment to a certificate, or revokes or amends a
15 certificate, neither the negative determination nor
16 the statement of reasons therefore shall be admissi-
17 ble in evidence, in any administrative or judicial pro-
18 ceeding, concerning any claim under the antitrust
19 laws.

20 (e) PUBLICATION OF DECISIONS.—The Attorney
21 General shall publish a notice in the Federal Register on
22 a timely basis of each decision made with respect to an
23 application for a certificate of review under this section
24 or the amendment or revocation of such a certificate, in

1 a manner that protects the confidentiality of any propri-
2 etary information relating to the application.

3 (f) ANNUAL REPORTS.—Every person to whom a cer-
4 tificate of review is issued shall submit to the Attorney
5 General an annual report, in such form and at such time
6 as the Attorney General may require, that contains any
7 necessary updates to the information required under sub-
8 section (b) and a description of the activities of the holder
9 under the certificate during the preceding year.

10 (g) RESTRICTIONS ON DISCLOSURE OF INFORMA-
11 TION.—

12 (1) WAIVER OF DISCLOSURE REQUIREMENTS
13 UNDER ADMINISTRATIVE PROCEDURE ACT.—Infor-
14 mation submitted by any person in connection with
15 the issuance, amendment, or revocation of a certifi-
16 cate of review shall be exempt from disclosure under
17 section 552 of title 5, United States Code.

18 (2) RESTRICTIONS ON DISCLOSURE OF COM-
19 MERCIAL OR FINANCIAL INFORMATION.—

20 (A) IN GENERAL.—Except as provided in
21 subparagraph (B), no officer or employee of the
22 United States shall disclose commercial or fi-
23 nancial information submitted in connection
24 with the issuance, amendment, or revocation of
25 a certificate of review if the information is priv-

1 ileged or confidential or if disclosure of the in-
2 formation would cause harm to the person who
3 submitted the information.

4 (B) EXCEPTIONS.—Subparagraph (A)
5 shall not apply with respect to information dis-
6 closed—

7 (i) upon a request made by the Con-
8 gress or any committee of the Congress,

9 (ii) in a judicial or administrative pro-
10 ceeding, subject to appropriate protective
11 orders,

12 (iii) with the consent of the person
13 who submitted the information,

14 (iv) in the course of making a deter-
15 mination with respect to the issuance,
16 amendment, or revocation of a certificate
17 of review, if the Attorney General deems
18 disclosure of the information to be nec-
19 essary in connection with making the de-
20 termination,

21 (v) in accordance with any require-
22 ment imposed by a statute of the United
23 States, or

24 (vi) in accordance with any rule or
25 regulation promulgated under subsection

(i) permitting the disclosure of the information to an agency of the United States or of a State on the condition that the agency will disclose the information only under the circumstances specified in clauses (i) through (v).

(3) PROHIBITION AGAINST USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTI-TRUST LAWS.—Any information disclosed in an application for a certificate of review under this section shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing whether a person is entitled to the protections provided by such a certificate.

SEC. 2504. NOTIFICATIONS PROVIDING REDUCTION IN CERTAIN PENALTIES UNDER ANTITRUST LAW FOR HEALTH CARE JOINT VENTURES.

(a) NOTIFICATIONS DESCRIBED.—

(1) SUBMISSION OF NOTIFICATION BY VENTURE.—Any party to a health care joint venture, acting on such venture's behalf, may, not later than 90 days after entering into a written agreement to form such venture or not later than 90 days after the date of the enactment of this Act, whichever is

1 later, file with the Attorney General a written notifi-
2 cation disclosing—

3 (A) the identities of the parties to such
4 venture,

5 (B) the nature and objectives of such ven-
6 ture, and

7 (C) such additional information as the At-
8 torney General may require by regulation.

9 (2) FILING FEE.—The Attorney General may
10 require a filing fee to be submitted with the notifica-
11 tion to cover the cost of publication and the cost of
12 administering this section, except that the amount of
13 such fee shall not exceed \$250.

14 (3) SUBMISSION OF ADDITIONAL INFORMA-
15 TION.—

16 (A) REQUEST OF ATTORNEY GENERAL.—
17 At any time after receiving a notification filed
18 under paragraph (1), the Attorney General may
19 require the submission of additional information
20 or documentary material relevant to the pro-
21 posed health care joint venture.

22 (B) PARTIES TO VENTURE.—Any party to
23 a health care joint venture may submit such ad-
24 ditional information on the venture's behalf as
25 may be appropriate to ensure that the venture

1 will receive the protections provided under sub-
2 section (b).

3 (C) REQUIRED SUBMISSION OF INFORMA-
4 TION ON CHANGES TO VENTURE.—A health
5 care joint venture for which a notification is in
6 effect under this section shall submit informa-
7 tion on any change in the membership of the
8 venture not later than 90 days after such
9 change occurs.

10 (4) PUBLICATION OF NOTIFICATION.—

11 (A) INFORMATION MADE PUBLICLY AVAIL-
12 ABLE.—Not later than 30 days after receiving
13 a notification with respect to a venture under
14 paragraph (1), the Attorney General shall pub-
15 lish in the Federal Register a notice with re-
16 spect to the venture that identifies the parties
17 to the venture and generally describes the pur-
18 pose and planned activity of the venture. Prior
19 to its publication, the contents of the notice
20 shall be made available to the parties to the
21 venture.

22 (B) RESTRICTION ON DISCLOSURE OF
23 OTHER INFORMATION.—All information and
24 documentary material submitted pursuant to
25 this section and all information obtained by the

1 Attorney General in the course of any investiga-
2 tion or case with respect to a potential violation
3 of the antitrust laws by the health care joint
4 venture (other than information and material
5 described in subparagraph (A)) shall be exempt
6 from disclosure under section 552 of title 5,
7 United States Code, and shall not be made pub-
8 licly available by any agency of the United
9 States to which such section applies except in
10 a judicial proceeding in which such information
11 and material is subject to any protective order.

12 (5) WITHDRAWAL OF NOTIFICATION.—Any per-
13 son who files a notification pursuant to this section
14 may withdraw such notification before a publication
15 by the Attorney General pursuant to paragraph (4).

16 (6) NO JUDICIAL REVIEW PERMITTED.—Any
17 action taken or not taken by the Attorney General
18 with respect to notifications filed pursuant to this
19 subsection shall not be subject to judicial review.

20 (b) PROTECTIONS FOR VENTURES SUBJECT TO NO-
21 TIFICATION.—

22 (1) IN GENERAL.—

23 (A) PROTECTIONS DESCRIBED.—Except as
24 provided in subsection (c), the provisions of
25 paragraphs (2), (3), (4), and (5) shall apply

1 with respect to any action under the antitrust
2 laws challenging conduct within the scope of a
3 notification which is in effect pursuant to sub-
4 section (a)(1).

5 (B) TIMING OF PROTECTIONS.—The pro-
6 tections described in this subsection shall apply
7 to the venture that is the subject of a notifica-
8 tion under subsection (a)(1) as of the earlier
9 of—

10 (i) the date of the publication in the
11 Federal Register of the notice published
12 with respect to the notification; or

13 (ii) if such notice is not published dur-
14 ing the period required under subsection
15 (a)(4), the expiration of the 30-day period
16 that begins on the date the Attorney Gen-
17 eral receives any necessary information re-
18 quired to be submitted under subsection
19 (a)(1) or any additional information re-
20 quired by the Attorney General under sub-
21 section (a)(3)(A).

22 (2) APPLICABILITY OF RULE OF REASON
23 STANDARD.—In any action under the antitrust laws,
24 the conduct of any person which is within the scope
25 of a notification filed under subsection (a) shall not

1 be deemed illegal per se, but shall be judged on the
2 basis of its reasonableness, taking into account all
3 relevant factors affecting competition, including, but
4 not limited to, effects on competition in relevant
5 markets.

6 (3) LIMITATION ON RECOVERY TO ACTUAL
7 DAMAGES AND INTEREST.—Notwithstanding section
8 4 of the Clayton Act, any person who is entitled to
9 recovery under the antitrust laws for conduct that is
10 within the scope of a notification filed under sub-
11 section (a) shall recover the actual damages sus-
12 tained by such person and interest calculated at the
13 rate specified in section 1961 of title 28, United
14 States Code, for the period beginning on the earliest
15 date for which injury can be established and ending
16 on the date of judgment, unless the court finds that
17 the award of all or part of such interest is unjust
18 under the circumstances.

19 (4) AWARD OF ATTORNEY'S FEES AND COSTS
20 OF SUIT.—

21 (A) IN GENERAL.—In any action under the
22 antitrust laws brought against a health care
23 joint venture for conduct that is within the
24 scope of a notification filed under subsection

(a), the court shall, at the conclusion of the action—

(i) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(ii) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(B) OFFSET IN CASES OF BAD FAITH.—

The court may reduce an award made pursuant to subparagraph (A) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

(5) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—

1 (A) IN GENERAL.—Any information dis-
2 closed in a notification submitted under sub-
3 section (a)(1) and the fact of the publication of
4 a notification by the Attorney General under
5 subsection (a)(4) shall only be admissible into
6 evidence in a judicial or administrative proceed-
7 ing for the sole purpose of establishing whether
8 a party to a health care joint venture is entitled
9 to the protections described in this subsection.

10 (B) ACTIONS OF ATTORNEY GENERAL.—
11 No action taken by the Attorney General pursu-
12 ant to this section shall be admissible into evi-
13 dence in any judicial or administrative proceed-
14 ing for the purpose of supporting or answering
15 any claim under the antitrust laws.

16 (c) EXCEPTION FOR CERTAIN ACTIVITIES.—

17 (1) ACTIVITIES DESCRIBED.—The protections
18 described in subsection (b) shall not apply to con-
19 duct which constitutes price-fixing, bid-rigging, or
20 market allocation, unless such conduct is related to
21 procompetitive aspects of a health care joint venture
22 (as determined in accordance with the process de-
23 scribed in paragraph (2)).

24 (2) PROCESS.—If conduct of a health care joint
25 venture which is subject to a notification under sub-

1 section (a)(1) is challenged for price-fixing, bid-rig-
2 ging, or market allocation, any party to the joint
3 venture shall be entitled to show the procompetitive
4 aspects of such conduct. The protections described
5 in subsection (b) shall not apply to the conduct if
6 the party is unable to show that the conduct is not
7 mere price-fixing, bid-rigging, or market allocation.

8 **SEC. 2505. REVIEW AND REPORTS ON SAFE HARBORS, CER-**
9 **TIFICATES OF REVIEW, AND NOTIFICATIONS.**

10 (a) IN GENERAL.—The Attorney General, in con-
11 sultation with the Secretary and the Chair, shall periodi-
12 cally review the safe harbors designated under section
13 2502, the certificates of review issued under section 2503,
14 and notification received under section 2504, and—

15 (1) with respect to the safe harbors, issue modi-
16 fications to such safe harbors in such manner as the
17 Attorney General considers appropriate in accord-
18 ance with the requirements of section 2502, which
19 modifications shall take effect 90 days after issu-
20 ance, unless disapproved by the Congress; and

21 (2) with respect to the certificates of review and
22 notifications, submit a report to Congress on the is-
23 suance of such certificates and receipt of notifica-
24 tions, including a description of the effect of such

certificates and notifications on increasing access to high quality health care services at reduced costs.

(b) RECOMMENDATIONS FOR LEGISLATION.—The Attorney General shall include in the reports submitted under subsection (a)(2) any recommendations of the Attorney General for legislation to improve the programs for the issuance of certificates of review and receipt of notifications established under this subtitle.

SEC. 2506. RULES, REGULATIONS, AND GUIDELINES.

(a) SAFE HARBORS, CERTIFICATES, AND NOTIFICATIONS.—The Attorney General, in consultation with the Secretary and the Chair, shall promulgate such rules, regulations, and guidelines as are necessary to carry out sections 2502, 2503, and 2504.

(b) GUIDANCE FOR PROVIDERS.—

(1) IN GENERAL.—To promote greater certainty regarding the application of the antitrust laws to activities in the health care market, the Attorney General, in consultation with the Secretary and the Chair, shall (not later than 1 year after the date of the enactment of this Act), taking into account the criteria used to designate safe harbors under section 2502 and grant certificates of review under section 2503, publish guidelines—

1 (A) to define or provide assistance in de-
2 termining relevant geographic and product mar-
3 kets for health care services and providers of
4 health care services;

5 (B) to further collaborative activities which
6 may be helpful to enhance services in under-
7 served and geographically disadvantaged areas
8 such as rural markets and inner cities;

9 (C) to assist collaboration between provid-
10 ers (such as hospital networks, physician-hos-
11 pital organizations, and other groups of provid-
12 ers) which will help provide health care services
13 more efficiently;

14 (D) to further activities by which public
15 health clinics (including community health cen-
16 ters and migrant health centers under title III
17 of the Public Health Service Act) may partici-
18 pate in networks and other collaborative activi-
19 ties in order to enhance services in underserved
20 areas;

21 (E) to assist providers of health care serv-
22 ices in analyzing whether the activities of such
23 providers may be subject to a safe harbor under
24 section 2502;

(F) to provide clarification for activities in the general subject matter areas described in the safe harbors in section 2502, but which fall outside the safe harbors; and

(G) to describe specific types of activities which would meet the requirements for issuance of a certificate of review under section 2503, and summarizing the factual and legal bases on which the activities would meet the requirements.

(2) PERIODIC UPDATE.—The Attorney General shall periodically update the guidelines published under paragraph (1) as the Attorney General considers appropriate.

(3) WAIVER OF ADMINISTRATIVE PROCEDURE ACT.—Section 553 of title 5, United States Code, shall not apply to the issuance of guidelines under paragraph (1).

SEC. 2507. ESTABLISHMENT OF HHS OFFICE OF HEALTH CARE COMPETITION POLICY.

(a) IN GENERAL.—There is established within the Department of Health and Human Services an Office to be known as the Office of Health Care Competition Policy (hereafter in this section referred to as the “Office”). The

1 Office shall be headed by a director, who shall be ap-
2 pointed by the Secretary.

3 (b) DUTIES.—The Office shall coordinate the respon-
4 sibilities of the Secretary under this subtitle and otherwise
5 assist the Secretary in developing policies relating to the
6 competitive and collaborative activities of providers of
7 health care services.

8 **SEC. 2508. DEFINITIONS.**

9 In this subtitle:

10 (1) The term “antitrust laws”—

11 (A) has the meaning given it in subsection
12 (a) of the first section of the Clayton Act (15
13 U.S.C. 12(a)), except that such term includes
14 section 5 of the Federal Trade Commission Act
15 (15 U.S.C. 45) to the extent such section ap-
16 plies to unfair methods of competition; and

17 (B) includes any State law similar to the
18 laws referred to in subparagraph (A).

19 (2) The term “Chair” means the Chair of the
20 Federal Trade Commission.

21 (3) The term “health benefit plan” means any
22 hospital or medical expense incurred policy or certifi-
23 cate, hospital or medical service plan contract, or
24 health maintenance subscriber contract, or a mul-
25 tiple employer welfare arrangement or employee ben-

1 efit plan (as defined under the Employee Retirement
2 Income Security Act of 1974) which provides bene-
3 fits with respect to health care services.

4 (4) The term “health care joint venture” means
5 a joint venture of 2 or more persons formed for the
6 purpose of providing health care services, including
7 attempts to enter into or perform a contract or
8 agreement to provide such services.

9 (5) The term “health care services” means any
10 services for which payment may be made under a
11 health benefit plan, including services related to the
12 delivery or administration of such services.

13 (6) The term “medical self-regulatory entity”
14 means a medical society or association, a specialty
15 board, a recognized accrediting agency, or a hospital
16 medical staff, and includes the members, officers,
17 employees, consultants, and volunteers or commit-
18 tees of such an entity.

19 (7) The term “person” includes a State or unit
20 of local government.

21 (8) The term “provider of health care services”
22 means any individual or entity that is engaged in the
23 delivery of health care services in a State and that
24 is required by State law or regulation to be licensed

1 or certified by the State to engage in the delivery of
2 such services in the State.

3 (9) The term "Secretary" means the Secretary
4 of Health and Human Services.

5 (10) The term "specialty group" means a medi-
6 cal specialty or subspecialty in which a provider of
7 health care services may be licensed to practice by
8 a State (as determined by the Secretary in consulta-
9 tion with the certification boards for such specialties
10 and subspecialties).

11 (11) The term "standard setting and enforce-
12 ment activities" means—

13 (A) accreditation of health care practition-
14 ers, health care providers, medical education in-
15 stitutions, or medical education programs,

16 (B) technology assessment and risk man-
17 agement activities,

18 (C) the development and implementation of
19 practice guidelines or practice parameters, or

20 (D) official peer review proceedings under-
21 taken by a hospital medical staff (or committee
22 thereof) or a medical society or association for
23 purposes of evaluating the professional conduct
24 or quality of health care provided by a medical
25 professional.

1 **Subtitle G—Encouraging Enforce-**
2 **ment Activities of Medical Self-**
3 **Regulatory Entities**

4 **PART 1—APPLICATION OF THE CLAYTON ACT TO**
5 **MEDICAL SELF-REGULATORY ENTITIES**

6 **SEC. 2601. ANTITRUST EXEMPTION FOR MEDICAL SELF-**
7 **REGULATORY ENTITIES.**

8 (a) IN GENERAL.—(1) Except as provided in para-
9 graph (2), no damages, interest on damages, cost of suit,
10 or attorney's fee may be recovered under section 4, 4A,
11 or 4C of the Clayton Act (15 U.S.C. 15, 15a, 15c), or
12 under any State law similar to such section, from any
13 medical self-regulatory entity (including its members, offi-
14 cers, employees, consultants, and volunteers or committees
15 thereof) as a result of engaging in standard setting or en-
16 forcement activities that are—

17 (A) designed to promote the quality of health
18 care provided to patients, and

19 (B) not conducted for purposes of financial
20 gain.

21 (2) Paragraph (1) shall not prohibit the recovery of
22 actual damages, interest on damages, the cost of suit, or
23 a reasonable attorney's fee under section 4 or 4A of the
24 Clayton Act (15 U.S.C. 15, 15a), or under any State law
25 similar to such section, by a State or the United States

1 from a medical self-regulatory entity (including its mem-
 2 bers, officers, employees, consultants, and volunteers or
 3 committees thereof) for injury sustained as a result of en-
 4 gaging in the conduct described in such paragraph.

5 (b) FEES.—In any action under section 4, 4C, or 16
 6 of the Clayton Act (15 U.S.C. 15, 15c, 26), or under a
 7 similar State law, brought against any medical self-regu-
 8 latory entity (including its members, officers, employees,
 9 consultants, and volunteers or committees thereof) as a
 10 result of engaging in conduct described in subsection
 11 (a)(1), the court shall award the cost of suit, including
 12 a reasonable attorney's fee, to a substantially prevailing
 13 defendant.

14 **SEC. 2602. DEFINITIONS.**

15 For purposes of this subtitle:

16 (1) The term “medical self-regulatory entity”
 17 means a medical society or association, a specialty
 18 board, a recognized accrediting agency, or a hospital
 19 medical staff.

20 (2) The term “standard setting and enforce-
 21 ment activities” means—

22 (A) accreditation of health care practition-
 23 ers, health care providers, medical education in-
 24 stitutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the quality of health care provided by a medical professional.

PART 2—CONSULTATION BY FEDERAL AGENCIES

SEC. 2611. CONSULTATION WITH MEDICAL SELF-REGULATORY ENTITIES RESPECTING MEDICAL PROFESSIONAL GUIDELINES AND STANDARDS.

Any Federal agency engaged in the establishment of medical professional standards shall consult with appropriate medical societies or associations, specialty boards, or recognized accrediting agencies, if available, in carrying out medical professional standard setting and guidelines or standards relating to the practice of medicine.

1 **Subtitle H—Reform of Clinical Lab-**
2 **oratory Requirements for Sim-**
3 **ple Tests**

4 **SEC. 2701. ELIMINATING CLIA REQUIREMENT FOR CERTIFI-**
5 **CATE OF WAIVER FOR SIMPLE LABORATORY**
6 **EXAMINATIONS AND PROCEDURES.**

7 (a) IN GENERAL.—Section 353 of the Public Health
8 Service Act (42 U.S.C. 263a) is amended—

9 (1) in subsection (b), by inserting before the pe-
10 riod at the end the following: “or unless the labora-
11 tory is exempt from the certificate requirement
12 under subsection (d)(2)”;

13 (2) by amending paragraph (2) of subsection
14 (d) to read as follows:

15 “(2) EXEMPTION FROM CERTIFICATE REQUIRE-
16 MENT FOR LABORATORIES PERFORMING ONLY SIM-
17 PLE EXAMINATIONS AND PROCEDURES.—A labora-
18 tory which performs only laboratory examinations
19 and procedures described in paragraph (3) is not re-
20 quired to have in effect a certificate under this sec-
21 tion.”;

22 (3) by striking paragraph (4) of subsection (d);
23 and

(4) in subsection (m)(1), by striking “, except that the Secretary” and all that follows and inserting a period.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first month beginning after the date of the enactment of this Act.

SEC. 2702. AMENDMENT RELATED TO SIMPLE LABORATORY EXAMINATIONS.

Section 353(d) of the Public Health Service Act (42 U.S.C. 263) is amended by striking paragraph (3) and inserting the following:

“(3) EXAMINATIONS AND PROCEDURES.—The examinations and procedures identified in paragraph (2) are simple laboratory examinations and procedures which have an insignificant risk of an erroneous result and include those which—

“(A) have been approved by the Food and Drug Administration for home use,

“(B) employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible,

“(C) the Secretary has determined pose no reasonable risk of serious harm to the patient if performed incorrectly, or

“(D)(i) are performed by or under the direction or supervision of or in collaboration with a doctor of medicine or osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located, or by an individual qualified to direct, supervise, or perform examinations and procedures under State laws or such standards as the Secretary may establish; and

“(ii) the patient is available for clinical observation; and

“(iii) prompt results are needed to evaluate, diagnose, and treat the patient or to avoid additional burdens on the patient that could result from not performing the test.

“(4) DEFINITION.—As used in this section, the term ‘simple laboratory examinations and procedures’ includes dipstick tests for total and allergen-specific IgE; microscopic examination of nasal smears (for cells and bacteria); mono spot tests; testing for theophylline using the Accu-Level method; microscopic urinalysis; vaginal wet mount; KOH prep, scabies prep; rapid strep antigen; nonautomated qualitative and quantitative semen analysis; pin worm; prostate smears; synovial fluid

1 analysis for inflammation and infection; post coital
2 test; fern test; occult blood; Gram stain; qualitative
3 drug screen; pulse oximetry; hemoglobin (by hand-
4 held hemoglobinometer); ASO, CRP, RF, and mono
5 screen; sickle cell screen; white blood cell count by
6 manual chamber count; peripheral blood smears;
7 sputum eosinophil; urine culture colony; urine sen-
8 sitivities; microscopic examination of hair morphol-
9 ogy; molluscum smear; fungal cultures, including
10 dermatophyte test medium; Tzank smear; Darkfield
11 examination; agglutination pregnancy test; urethral
12 gram stains, and centrifugal hematology, including
13 white blood cell count, hematocrit, differential, and
14 platelet count.”.

15 **SEC. 2703. AMENDMENT RELATED TO STUDY.**

16 (a) STUDY.—The Secretary of Health and Human
17 Services, acting through the Centers for Disease Control
18 and Prevention, shall use existing appropriations to con-
19 duct the study required by section 4 of the Clinical Lab-
20 oratory Improvement Amendments of 1988 (42 U.S.C.
21 263a note). The Secretary shall report the results of such
22 study to the Committee on Ways and Means and the Com-
23 mittee on Energy and Commerce of the House of Rep-
24 resentatives and the Committee on Finance and the Com-

1 mittee on Labor and Human Resources of the Senate not
2 later than May 1, 1996.

3 (b) SUNSET.—If the results of the study described
4 in subsection (a) are not reported to the committees of
5 Congress by May 1, 1996, section 353 of the Public
6 Health Service Act shall not be in effect after May 1,
7 1996.

8 **SEC. 2704. AMENDMENTS RELATED TO THE CLINICAL LAB-**
9 **ORATORY IMPROVEMENT ADVISORY COM-**
10 **MITTEE.**

11 The Secretary of Health and Human Services shall
12 revise the membership of the Clinical Laboratory Improve-
13 ment Advisory Committee established by the Secretary in
14 regulations to implement section 353 of the Public Health
15 Service Act (subpart T of part 493 of title 42 Code of
16 Federal Regulations) to contain, in the membership which
17 does not include ex-officio members or officers or employ-
18 ees of the Federal Government, a number of practicing
19 physicians which is proportionate to the number of physi-
20 cian laboratories regulated under such section 353. For
21 purposes of this section, the term “practicing physician”
22 means a licensed doctor of medicine or osteopathy who
23 spends at least 80 percent of the physician’s professional
24 time in direct patient care and who directs an in-office
25 clinical laboratory for the physician’s patients.

Subtitle I—Miscellaneous Provisions

SEC. 2801. REQUIREMENT THAT CERTAIN AGENCIES PREFUND GOVERNMENT HEALTH BENEFITS CONTRIBUTIONS FOR THEIR ANNUITANTS.

(a) DEFINITIONS.—For the purpose of this section—

(1) the term “agency” means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the budget of the United States Government submitted by the President;

(2) the term “health benefits plan” means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term “health-benefits coverage” means coverage under a health benefits plan”;

(4) an individual shall be considered to be an “annuitant of an agency” if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual’s service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

(5) the term "Office" means the Office of Personnel Management.

(b) PREFUNDING REQUIREMENT.—

(1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case of the agency with the greatest number of employees, as determined by the Office) shall be required to prepay the Government contributions which are or will be required in connection with providing health-benefits coverage for annuitants of such agency.

(2) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section. The regulations shall be designed to ensure at least the following:

(A) Amounts paid by each agency shall be sufficient to cover the amounts which would otherwise be payable by such agency (on a "pay-as-you-go" basis), on or after the applicable effective date under paragraph (1), on behalf of—

1 (i) individuals who are annuitants of
2 the agency as of such effective date; and

3 (ii) individuals who are employed by
4 the agency as of such effective date, or
5 who become employed by the agency after
6 such effective date, after such individuals
7 have become annuitants of the agency (in-
8 cluding their survivors).

9 (B)(i) For purposes of determining any
10 amounts payable by an agency—

11 (I) this section shall be treated as if
12 it had taken effect at the beginning of the
13 20-year period which ends on the effective
14 date applicable under paragraph (1) with
15 respect to such agency; and

16 (II) in addition to any amounts pay-
17 able under subparagraph (A), each agency
18 shall also be responsible for paying any
19 amounts for which it would have been re-
20 sponsible, with respect to the 20-year pe-
21 riod described in subclause (I), in connec-
22 tion with any individuals who are annu-
23 itants or employees of the agency as of the
24 applicable effective date under paragraph
25 (1).

(ii) Any amounts payable under this subparagraph for periods preceding the applicable effective date under paragraph (1) shall be payable in equal installments over the 20-year period beginning on such effective date.

(c) FASB STANDARDS.—Regulations under subsection (b) shall be in conformance with the provisions of standard 106 of the Financial Accounting Standards Board, issued in December 1990.

(d) CLARIFICATION.—Nothing in this section shall be considered to permit or require duplicative payments on behalf of any individuals.

(e) DRAFT LEGISLATION.—The Office shall prepare and submit to Congress any draft legislation which may be necessary in order to carry out this section.

SEC. 2802. INELIGIBILITY OF ALIENS FOR SSI AND MEDICAID.

(a) IN GENERAL.—Notwithstanding any other provision of law and except as provided in subsections (b) and (c), no alien shall be eligible for any program referred to in subsection (d).

(b) EXCEPTIONS.—

(1) REFUGEE EXCEPTION.—Subsection (a) shall not apply to an alien admitted to the United States as a refugee under section 207 of the Immi-

1 gration and Nationality Act until 6 years after the
2 date of such alien's arrival into the United States.

3 (2) AGED EXCEPTION.—Subsection (a) shall
4 not apply to an alien who—

5 (A) has been lawfully admitted to the
6 United States for permanent residence;

7 (B) is over 75 years of age; and

8 (C) has resided in the United States for at
9 least 5 years.

10 (3) CURRENT RESIDENT EXCEPTION.—Sub-
11 section (a) shall not apply to the eligibility of an
12 alien for a program referred to in subsection (d)
13 until 1 year after the date of the enactment of this
14 Act if, on such date of enactment, the alien is resid-
15 ing in the United States and is eligible for the pro-
16 gram.

17 (c) PROGRAMS FOR WHICH ALIENS MAY BE ELIGI-
18 BLE.—The limitation under subsection (a) shall not apply
19 to medical assistance with respect to emergency services
20 (as defined for purposes of section 1916(a)(2)(D) of the
21 Social Security Act).

22 (d) PROGRAMS FOR WHICH ALIENS ARE INELI-
23 GIBLE.—The programs referred to in this subsection are
24 the following:

(1) The program of medical assistance under title XIX of the Social Security Act, except emergency services as provided in subsection (c).

(2) The supplemental security income program under title XVI of the Social Security Act.

(e) NOTIFICATION OF ALIENS.—Any Federal agency that administers a program referred to in subsection (d) shall, directly or through the States, notify each alien receiving benefits under the program whose eligibility for the program is or will be terminated by reason of this section.

SEC. 2803. LIMITATION ON SSI BENEFITS FOR DRUG AND ALCOHOL ADDICTS.

(a) IN GENERAL.—

(1) LIMITATION DESCRIBED.—Section 1614(a) of the Social Security Act (42 U.S.C. 1382c(a)) is amended by adding at the end the following:

“(5)(A) The Secretary shall identify all recipients of benefits under this title by reason of disability whose disability is a result of addiction to illegal drugs.

“(B) The Secretary shall periodically, on a random basis, test each recipient identified under subparagraph (A) to determine whether the recipient is using illegal drugs.

“(C)(i) Notwithstanding any other provision of this title, any individual who is determined under subpara-

graph (B) to be using illegal drugs, or who refuses to submit to testing as provided for under subparagraph (B), shall not be eligible for benefits under this title for a period of at least 1 year.

“(ii) The period of ineligibility under clause (i) shall terminate (after the last day of such 1-year period) if the individual has 2 tests (at least 2 months apart and not paid for through Federal funds) which establish that the recipient is not using illegal drugs.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to quarters beginning after the expiration of the 6-month period that begins on the date of the enactment of this Act.

(b) REPRESENTATIVE PAYEE REFORMS.—

(1) AUTHORITY OF GOVERNMENT AGENCIES TO BECOME PAID REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(ii) of such Act (42 U.S.C. 1383(a)(2)(D)(ii)) is amended by adding at the end the following: “The term ‘qualified organization’ also includes any government agency that meets the requirements of items (aa) and (bb) of subclause (II).”.

(2) MAXIMUM FEE PAYABLE TO REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(i) of such Act (42 U.S.C. 1383(a)(2)(D)(i)) is amended by striking

- 1 “the lesser of—” and all that follows and inserting
 2 “10 percent of the monthly benefit involved.”.

3 **TITLE III—LONG-TERM CARE**

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Subtitle A—Tax Treatment of Long-term Care Insurance

- Sec. 3001. Treatment of long-term care insurance or plans.
 Sec. 3002. Exclusion for benefits provided under long-term care insurance; inclusion of employer-provided coverage.
 Sec. 3003. Qualified long-term services treated as medical care.
 Sec. 3004. Effective date.

Subtitle B—Establishment of Federal Standards for Long-term Care Insurance

- Sec. 3101. Establishment of Federal standards for long-term care insurance.

“TITLE XXVII—LONG-TERM CARE INSURANCE STANDARDS

“PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

- “Sec. 2701. Standards.

“PART B—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

- “Sec. 2711. Implementation of policy standards.
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“PART C—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

- “Sec. 2721. Long-term care insurance policy defined.
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“PART D—MISCELLANEOUS PROVISIONS

- “Sec. 2731. Funding for long-term care insurance information, counseling, and assistance.
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Subtitle C—Protection of Assets Under Medicaid Through Use of Qualified Long-term Care Insurance

- Sec. 3201. Protection of assets through use of qualified long-term care insurance.

Subtitle D—Studies

Sec. 3301. Feasibility of encouraging health care providers to donate services to homebound patients.

Sec. 3302. Feasibility of tax credit for heads of households who care for elderly family members in their homes.

Sec. 3303. Case management of current long-term care benefits.

Subtitle E—Volunteer Service Credit Demonstration Projects

Sec. 3401. Amendment to the Older Americans Act of 1965.

1 Subtitle A—Tax Treatment of Long-

2 term Care Insurance

3 SEC. 3001. TREATMENT OF LONG-TERM CARE INSURANCE

4 OR PLANS.

5 (a) GENERAL RULE.—Subpart E of part I of sub-
6 chapter L of chapter 1 of the Internal Revenue Code of
7 1986 is amended by inserting after section 818 the follow-
8 ing new section:

9 “SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE

10 OR PLANS.

11 “(a) GENERAL RULE.—For purposes of this part, a
12 long-term care insurance contract shall be treated as an
13 accident or health insurance contract.

14 “(b) LONG-TERM CARE INSURANCE CONTRACT.—

15 “(1) IN GENERAL.—For purposes of this part,
16 the term ‘long-term care insurance contract’ means
17 any insurance contract issued if—

18 “(A) the only insurance protection pro-
19 vided under such contract is coverage of quali-

1 fied long-term care services and benefits inci-
2 dental to such coverage,

3 “(B) the maximum benefit under the pol-
4 icy for expenses incurred for any day does not
5 exceed \$200,

6 “(C) such contract does not cover expenses
7 incurred for services or items to the extent that
8 such expenses are reimbursable under title
9 XVIII of the Social Security Act or would be so
10 reimbursable but for the application of a de-
11 ductible or coinsurance amount,

12 “(D) such contract is guaranteed renew-
13 able,

14 “(E) such contract does not have any cash
15 surrender value, and

16 “(F) all refunds of premiums, and all pol-
17 icyholder dividends or similar amounts, under
18 such contract are to be applied as a reduction
19 in future premiums or to increase future bene-
20 fits.

21 “(2) SPECIAL RULES.—

22 “(A) PER DIEM, ETC. PAYMENTS PER-
23 MITTED.—A contract shall not fail to be treated
24 as described in paragraph (1)(A) by reason of
25 payments being made on a per diem or other

1 periodic basis without regard to the expenses
 2 incurred during the period to which the pay-
 3 ments relate.

4 “(B) CONTRACT MAY COVER MEDICARE
 5 REIMBURSABLE EXPENSES WHERE MEDICARE
 6 IS SECONDARY PAYOR.—Paragraph (1)(C) shall
 7 not apply to expenses which are reimbursable
 8 under title XVIII of the Social Security Act
 9 only as a secondary payor.

10 “(C) REFUNDS OF PREMIUMS.—Paragraph
 11 (1)(F) shall not apply to any refund of pre-
 12 miums on surrender or cancellation of the con-
 13 tract.

14 “(c) QUALIFIED LONG-TERM CARE SERVICES.—For
 15 purposes of this section—

16 “(1) IN GENERAL.—The term ‘qualified long-
 17 term care services’ means necessary diagnostic, pre-
 18 ventive, therapeutic, and rehabilitative services, and
 19 maintenance or personal care services, which—

20 “(A) are required by a chronically ill indi-
 21 vidual in a qualified facility, and

22 “(B) are provided pursuant to a plan of
 23 care prescribed by a licensed health care practi-
 24 tioner.

25 “(2) CHRONICALLY ILL INDIVIDUAL.—

“(A) IN GENERAL.—The term ‘chronically ill individual’ means any individual who has been certified by a licensed health care practitioner as—

“(i)(I) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)) for a period of at least 90 days due to a loss of functional capacity, or

“(II) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subclause (I), or

“(ii) having a similar level of disability due to cognitive impairment.

“(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

“(i) MOBILITY.—The process of walking or wheeling on a level surface which may include the use of an assistive device such as a cane, walker, wheelchair, or brace.

1 “(ii) DRESSING.—The overall complex
2 behavior of getting clothes from closets
3 and drawers and then getting dressed.

4 “(iii) TOILETING.—The act of going
5 to the toilet room for bowel and bladder
6 function, transferring on and off the toilet,
7 cleaning after elimination, and arranging
8 clothes or the ability to voluntarily control
9 bowel and bladder function, or in the event
10 of incontinence, the ability to maintain a
11 reasonable level of personal hygiene.

12 “(iv) TRANSFER.—The process of get-
13 ting in and out of bed or in and out of a
14 chair or wheelchair.

15 “(v) EATING.—The process of getting
16 food from a plate or its equivalent into the
17 mouth.

18 “(3) QUALIFIED FACILITY.—The term ‘quali-
19 fied facility’ means—

20 “(A) a nursing, rehabilitative, hospice, or
21 adult day care facility (including a hospital, re-
22 tirement home, nursing home, skilled nursing
23 facility, intermediate care facility, or similar in-
24 stitution)—

1 “(i) which is licensed under State law,

2 or

3 “(ii) which is a certified facility for
4 purposes of title XVIII or XIX of the So-
5 cial Security Act, or

6 “(B) an individual’s home if a licensed
7 health care practitioner certifies that without
8 home care the individual would have to be cared
9 for in a facility described in subparagraph (A).

10 “(4) MAINTENANCE OR PERSONAL CARE SERV-
11 ICES.—The term ‘maintenance or personal care serv-
12 ices’ means any care the primary purpose of which
13 is to provide needed assistance with any of the ac-
14 tivities of daily living described in paragraph (2)(B).

15 “(5) LICENSED HEALTH CARE PRACTI-
16 TIONER.—The term ‘licensed health care practi-
17 tioner’ means any physician (as defined in section
18 1861(r) of the Social Security Act) and any reg-
19 istered professional nurse, licensed social worker, or
20 other individual who meets such requirements as
21 may be prescribed by the Secretary.

22 “(d) CONTINUATION COVERAGE EXCISE TAX NOT
23 TO APPLY.—This section shall not apply in determining
24 whether section 4980B (relating to failure to satisfy con-

1 tinuation coverage requirements of group health plans) ap-
2 plies.

3 “(e) INFLATION ADJUSTMENT OF \$200 BENEFIT
4 LIMIT.—

5 “(1) IN GENERAL.—In the case of a calendar
6 year after 1994, the \$200 amount contained in sub-
7 section (b)(1)(B) shall be increased for such cal-
8 endar year by the medical care cost adjustment for
9 such calendar year. If any increase determined
10 under the preceding sentence is not a multiple of
11 \$10, such increase shall be rounded to the nearest
12 multiple of \$10.

13 “(2) MEDICAL CARE COST ADJUSTMENT.—For
14 purposes of paragraph (1), the medical care cost ad-
15 justment for any calendar year is the percentage (if
16 any) by which—

17 “(A) the medical care component of the
18 Consumer Price Index (as defined in section
19 1(f)(5)) for August of the preceding calendar
20 year, exceeds

21 “(B) such component for August of
22 1993.”.

23 “(b) RESERVES.—Clause (iii) of section 807(d)(3)(A)
24 is amended by inserting “(other than a long-term care in-

1 surance contract within the meaning of section 818A)”
 2 after “contract”.

3 (c) CLERICAL AMENDMENT.—The table of sections
 4 for such subpart E is amended by inserting after the item
 5 relating to section 818 the following new item:

“Sec. 818A. Treatment of long-term care insurance or plans.”.

6 **SEC. 3002. EXCLUSION FOR BENEFITS PROVIDED UNDER**
 7 **LONG-TERM CARE INSURANCE; INCLUSION**
 8 **OF EMPLOYER-PROVIDED COVERAGE.**

9 (a) IN GENERAL.—Subsection (a) of section 104 of
 10 the Internal Revenue Code of 1986 (relating to compensa-
 11 tion for injuries or sickness) is amended by striking “and”
 12 at the end of paragraph (4), by striking the period at the
 13 end of paragraph (5) and inserting “, and”, and by insert-
 14 ing after paragraph (4) the following new paragraph:

15 “(6) benefits under a long-term care insurance
 16 contract (as defined in section 818A(b)).”.

17 (b) INCLUSION OF EMPLOYER-PROVIDED COV-
 18 ERAGE.—Section 106 of such Code (relating to contribu-
 19 tions by employer to accident and health plans) is amend-
 20 ed by adding at the end thereof the following sentence:
 21 “The preceding sentence shall not apply to any plan pro-
 22 viding coverage for long-term care services.”.

1 **SEC. 3003. QUALIFIED LONG-TERM SERVICES TREATED AS**
2 **MEDICAL CARE.**

3 (a) **GENERAL RULE.**—Paragraph (1) of section
4 213(d) of the Internal Revenue Code of 1986 (defining
5 medical care) is amended by striking “or” at the end of
6 subparagraph (B), by redesignating subparagraph (C) as
7 subparagraph (D), and by inserting after subparagraph
8 (B) the following new subparagraph:

9 “(C) for qualified long-term care services
10 (as defined in section 818A(c)), or”.

11 (b) **DEDUCTION FOR LONG-TERM CARE EXPENSES**
12 **FOR PARENT OR GRANDPARENT.**—Section 213 of such
13 Code (relating to deduction for medical expenses) is
14 amended by adding at the end the following new sub-
15 section:

16 “(g) **SPECIAL RULE FOR CERTAIN LONG-TERM CARE**
17 **EXPENSES.**—For purposes of subsection (a), the term ‘de-
18 pendent’ shall include any parent or grandparent of the
19 taxpayer for whom the taxpayer has expenses for long-
20 term care services described in section 818A(c), but only
21 to the extent of such expenses.”.

22 (c) **TECHNICAL AMENDMENTS.**—

23 (1) Subparagraph (D) of section 213(d)(1) of
24 such Code (as redesignated by subsection (a)) is
25 amended by striking “subparagraphs (A) and (B)”
26 and inserting “subparagraphs (A), (B), and (C)”.

1 (2)(A) Paragraph (1) of section 213(d) of such
2 Code is amended by adding at the end thereof the
3 following new flush sentence:

4 “In the case of a long-term care insurance contract
5 (as defined in section 818A), only eligible long-term
6 care premiums (as defined in paragraph (10)) shall
7 be taken into account under subparagraph (D).”

8 (B) Subsection (d) of section 213 is amended
9 by adding at the end the following new paragraph:

10 “(10) ELIGIBLE LONG-TERM CARE PRE-
11 MIUMS.—

12 “(A) IN GENERAL.—For purposes of this
13 section, the term ‘eligible long-term care pre-
14 miums’ means the amount paid during a tax-
15 able year for any long-term care insurance con-
16 tract (as defined in section 818A) covering an
17 individual, to the extent such amount does not
18 exceed the limitation determined under the fol-
19 lowing table:

| “In the case of an individual with an attained age before the close of the taxable year of: | The limitation is: |
|--|-------------------------------|
| 40 or less | \$200 |
| More than 40 but not more than 50 | 375 |
| More than 50 but not more than 60 | 750 |
| More than 60 but not more than 70 | 1,600 |
| More than 70 | 2,000. |

20 “(B) INDEXING.—

21 “(i) IN GENERAL.—In the case of any
22 taxable year beginning in a calendar year

1 after 1993, each dollar amount contained
2 in paragraph (1) shall be increased by the
3 medical care cost adjustment of such
4 amount for such calendar year. If any in-
5 crease determined under the preceding sen-
6 tence is not a multiple of \$10, such in-
7 crease shall be rounded to the nearest mul-
8 tiple of \$10.

9 “(ii) MEDICAL CARE COST ADJUST-
10 MENT.—For purposes of clause (i), the
11 medical care cost adjustment for any cal-
12 endar year is the percentage (if any) by
13 which—

14 “(I) the medical care component
15 of the Consumer Price Index (as de-
16 fined in section 1(f)(5)) for August of
17 the preceding calendar year, exceeds

18 “(II) such component for August
19 of 1991.”.

20 (3) Paragraph (6) of section 213(d) of such
21 Code is amended—

22 (A) by striking “subparagraphs (A) and
23 (B)” and inserting “subparagraphs (A), (B),
24 and (C)”, and

1 (B) by striking “paragraph (1)(C)” in sub-
2 paragraph (A) and inserting “paragraph
3 (1)(D)”.

4 (4) Paragraph (7) of section 213(d) of such
5 Code is amended by striking “subparagraphs (A)
6 and (B)” and inserting “subparagraphs (A), (B),
7 and (C)”.

8 **SEC. 3004. EFFECTIVE DATE.**

9 The amendments made by this subtitle shall apply to
10 taxable years beginning after December 31, 1994.

11 **Subtitle B—Establishment of Fed-**
12 **eral Standards for Long-term**
13 **Care Insurance**

14 **SEC. 3101. ESTABLISHMENT OF FEDERAL STANDARDS FOR**
15 **LONG-TERM CARE INSURANCE.**

16 (a) IN GENERAL.—The Public Health Service Act is
17 amended—

18 (1) by redesignating title XXVII (42 U.S.C.
19 300cc et seq.) as title XXVIII; and

20 (2) by inserting after title XXVI the following
21 new title:

“TITLE XXVII—LONG-TERM CARE INSURANCE STANDARDS

“PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

“SEC. 2701. STANDARDS.

“(a) APPLICATION OF STANDARDS.—

“(1) NAIC.—The Secretary shall request that the National Association of Insurance Commissioners (hereinafter in this title referred to as the ‘NAIC’)—

“(A) develop specific standards that incorporate the requirements of this title; and

“(B) report to the Secretary on such standards,

by not later than 12 months after enactment of this title. If the NAIC develops such model standards that incorporate the requirements of this title within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under this title.

“(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Secretary shall promulgate, within 12 months after such

1 deadline, a regulation that provides standards that
2 incorporate the requirements of this title and such
3 standards shall apply as provided for in this title.

4 “(3) RELATION TO STATE LAW.—Nothing in
5 this title shall be construed as preventing a State
6 from applying standards that provide greater protec-
7 tion to policyholders of long-term care insurance
8 policies than the standards promulgated under this
9 title, except that such State standards may not be
10 inconsistent or in conflict with any of the require-
11 ments of this title.

12 “(b) DEADLINE FOR APPLICATION OF STAND-
13 ARDS.—

14 “(1) IN GENERAL.—Subject to paragraph (2),
15 the date specified in this subsection for a State is—

16 “(A) the date the State adopts the stand-
17 ards established under subsection (a)(1); or

18 “(B) the date that is 1 year after the first
19 day of the first regular legislative session that
20 begins after the date such standards are first
21 established under subsection (a)(2);

22 whichever is earlier.

23 “(2) STATE REQUIRING LEGISLATION.—In the
24 case of a State which the Secretary identifies, in
25 consultation with the NAIC, as—

“(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

“(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1994. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

“(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

“(1) minimum Federal standards for long-term care insurance consistent with the provisions of this title;

“(2) standards for the enhanced protection of consumers with long-term care insurance;

“(3) procedures for the modification of the standards established under paragraph (1) in a

1 manner consistent with future laws to expand exist-
2 ing Federal or State long-term care benefits or es-
3 tablish a comprehensive Federal or State long-term
4 care benefit program; and

5 “(4) other activities determined appropriate by
6 Congress.

7 “(d) CONSULTATION.—In establishing standards and
8 models of benefits under this section, the Secretary shall
9 provide for and consult with an advisory committee to be
10 chosen by the Secretary, and composed of—

11 “(1) three individuals who are representatives
12 of carriers;

13 “(2) three individuals who are representatives
14 of consumer groups;

15 “(3) three representatives who are representa-
16 tives of providers of long-term care services;

17 “(4) three other individuals who are not rep-
18 resentatives of carriers or of providers of long-term
19 care services and who have expertise in the delivery
20 and financing of such services; and

21 “(5) the Secretary of Veterans Affairs.

22 “(e) DUTIES.—The advisory committee established
23 under subsection (d) shall—

1 “(1) recommend the appropriate inflationary
2 index to be used with respect to the inflation protec-
3 tion benefit portion of the standards;

4 “(2) recommend the uniform needs assessment
5 mechanism to be used in determining the eligibility
6 of individuals for benefits under a policy;

7 “(3) recommend appropriate standards for ben-
8 efits under section 2715(c); and

9 “(4) perform such other activities as deter-
10 mined appropriate by the Secretary.

11 “(f) ADMINISTRATIVE PROVISIONS.—The following
12 provisions of section 1886(e)(6) of the Social Security Act
13 shall apply to the advisory committee chosen under sub-
14 section (d) in the same manner as such provisions apply
15 under such section:

16 “(1) Subparagraph (C) (relating to staffing and
17 administration).

18 “(2) Subparagraph (D) (relating to compensa-
19 tion of members).

20 “(3) Subparagraph (F) (relating to access to
21 information).

22 “(4) Subparagraph (G) (relating to use of
23 funds).

24 “(5) Subparagraph (H) (relating to periodic
25 GAO audits).

1 “(6) Subparagraph (J) (relating to requests for
2 appropriations).

3 “PART B—ESTABLISHMENT AND IMPLEMENTATION OF
4 LONG-TERM CARE INSURANCE POLICY STANDARDS

5 “SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.

6 “(a) IN GENERAL.—

7 “(1) REGULATORY PROGRAM.—No long-term
8 care policy (as defined in section (2721)) may be is-
9 sued, sold, or offered for sale as a long-term care in-
10 surance policy in a State on or after the date speci-
11 fied in section 2701(b) unless—

12 “(A) the Secretary determines that the
13 State has established a regulatory program
14 that—

15 “(i) provides for the application and
16 enforcement of the standards established
17 under section 2701(a); and

18 “(ii) complies with the requirements
19 of subsection (b);

20 by the date specified in section 2701(b), and
21 the policy has been approved by the State com-
22 missioner or superintendent of insurance under
23 such program; or

24 “(B) if the State has not established such
25 a program, or if the State’s regulatory program

1 has been decertified, the policy has been cer-
2 tified by the Secretary (in accordance with such
3 procedures as the Secretary may establish) as
4 meeting the standards established under section
5 2701(a) by the date specified in section
6 2701(b).

7 For purposes of this subsection, the advertising or
8 soliciting with respect to a policy, directly or indi-
9 rectly, shall be deemed the offering for sale of the
10 policy.

11 “(2) REVIEW OF STATE REGULATORY PRO-
12 GRAMS.—The Secretary periodically shall review reg-
13 ulatory programs described in paragraph (1)(A) to
14 determine if they continue to provide for the applica-
15 tion and enforcement of the standards and proce-
16 dures established under section 2701(a) and (b). If
17 the Secretary determines that a State regulatory
18 program no longer meets such standards and re-
19 quirements, before making a final determination, the
20 Secretary shall provide the State an opportunity to
21 adopt such a plan of correction as would permit the
22 program to continue to meet such standards and re-
23 quirements. If the Secretary makes a final deter-
24 mination that the State regulatory program, after
25 such an opportunity, fails to meet such standards

1 and requirements, the Secretary shall assume re-
2 sponsibility under paragraph (1)(B) with respect to
3 certifying policies in the State and shall exercise full
4 authority under section 2701 for carriers, agents, or
5 associations or its subsidiary in the State plans in
6 the State.

7 “(b) ADDITIONAL REQUIREMENTS FOR APPROVAL
8 OF STATE REGULATORY PROGRAMS.—For purposes of
9 subsection (a)(1)(A)(ii), the requirements of this sub-
10 section for a State regulatory program are as follows:

11 “(1) ENFORCEMENT.—The enforcement under
12 the program—

13 “(A) shall be designed in a manner so as
14 to secure compliance with the standards within
15 30 days after the date of a finding of non-
16 compliance with such standards; and

17 “(B) shall provide for notice in the annual
18 report required under paragraph (5) to the Sec-
19 retary of cases where such compliance is not se-
20 cured within such 30-day period.

21 “(2) PROCESS.—The enforcement process
22 under each State regulatory program shall provide
23 for—

1 “(A) procedures for individuals and enti-
2 ties to file written, signed complaints respecting
3 alleged violations of the standards;

4 “(B) responding on a timely basis to such
5 complaints;

6 “(C) the investigation of—

7 “(i) those complaints which have a
8 reasonable probability of validity, and

9 “(ii) such other alleged violations of
10 the standards as the program finds appro-
11 priate; and

12 “(D) the imposition of appropriate sanc-
13 tions (which include, in appropriate cases, the
14 imposition of a civil money penalty as provided
15 for in section 2718) in the case of a carrier,
16 agent, or association or its subsidiary deter-
17 mined to have violated the standards.

18 “(3) CONSUMER ACCESS TO COMPLIANCE IN-
19 FORMATION.—

20 “(A) IN GENERAL.—A State regulatory
21 program must provide for consumer access to
22 complaints filed with the State commissioner or
23 superintendent of insurance with respect to
24 long-term care insurance policies.

1 “(B) CONFIDENTIALITY.—The access pro-
2 vided under subparagraph (A) shall be limited
3 to the extent required to protect the confiden-
4 tiality of the identity of individual policyholders.

5 “(4) PROCESS FOR APPROVAL OF PREMIUMS.—

6 “(A) IN GENERAL.—Each State regulatory
7 program shall—

8 “(i) provide for a process for approv-
9 ing or disapproving proposed premium in-
10 creases or decreases with respect to long-
11 term care insurance policies; and

12 “(ii) establish a policy for receipt and
13 consideration of public comments before
14 approving such a premium increase or de-
15 crease.

16 “(B) CONDITIONS FOR APPROVAL.—No
17 premium increase shall be approved (or deemed
18 approved) under subparagraph (A) unless the
19 proposed increase is accompanied by an actuar-
20 ial memorandum which—

21 “(i) includes a description of the as-
22 sumptions that justify the increase;

23 “(ii) contains such information as
24 may be required under the Standards; and

25 “(iii) is made available to the public.

1 “(C) APPLICATION.—Except as provided in
2 subparagraph (D), this paragraph shall not
3 apply to a group long-term care insurance pol-
4 icy issued to a group described in section
5 4(E)(1) of the NAIC Long Term Care Insur-
6 ance Model Act (effective January 1991), ex-
7 cept that such group policy shall, pursuant to
8 guidelines developed by the NAIC, provide no-
9 tice to policyholders and certificate holders of
10 any premium change under such group policy.

11 “(D) EXCEPTION.—Subparagraph (C)
12 shall not apply to—

13 “(i) group conversion policies;

14 “(ii) the group continuation feature of
15 a group policy if the insurer separately
16 rates employee and continuation coverages;
17 and

18 “(iii) group policies where the func-
19 tion of the employer is limited solely to col-
20 lecting premiums (through payroll deduc-
21 tions or dues checkoff) and remitting them
22 to the insurer.

23 “(E) CONSTRUCTION.—Nothing in this
24 paragraph shall be construed as preventing the
25 NAIC from promulgating standards, or a State

1 from enacting and enforcing laws, with respect
2 to premium rates or loss ratios for all, including
3 group, long-term care insurance policies.

4 “(5) ANNUAL REPORTS.—Each State regu-
5 latory program shall provide for annual reports to be
6 submitted to the Secretary on the implementation
7 and enforcement of the standards in the State, in-
8 cluding information concerning violations in excess
9 of 30 days.

10 “(6) ACCESS TO OTHER INFORMATION.—The
11 State regulatory program must provide for consumer
12 access to actuarial memoranda provided under para-
13 graph (4).

14 “(7) DEFAULT.—In the case of a State without
15 a regulatory program approved under subsection (a),
16 the Secretary shall provide for the enforcement ac-
17 tivities described in subsection (c).

18 “(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

19 “(1) IN GENERAL.—The Secretary shall exer-
20 cise authority under this section in the case of a
21 State that does not have a regulatory program ap-
22 proved under this section.

23 “(2) COMPLAINTS AND INVESTIGATIONS.—The
24 Secretary shall establish procedures—

1 “(A) for individuals and entities to file
2 written, signed complaints respecting alleged
3 violations of the requirements of this title;

4 “(B) for responding on a timely basis to
5 such complaints; and

6 “(C) for the investigation of—

7 “(i) those complaints that have a rea-
8 sonable probability of validity; and

9 “(ii) such other alleged violations of
10 the requirements of this title as the Sec-
11 retary determines to be appropriate.

12 In conducting investigations under this subsection,
13 agents of the Secretary shall have reasonable access
14 necessary to enable such agents to examine evidence
15 of any carrier, agent, or association or its subsidiary
16 being investigated.

17 “(3) HEARINGS.—

18 “(A) IN GENERAL.—Prior to imposing an
19 order described in paragraph (4) against a car-
20 rier, agent, or association or its subsidiary
21 under this section for a violation of the require-
22 ments of this title, the Secretary shall provide
23 the carrier, agent, association or subsidiary
24 with notice and, upon request made within a
25 reasonable time (of not less than 30 days, as

1 established by the Secretary by regulation) of
2 the date of the notice, a hearing respecting the
3 violation.

4 “(B) CONDUCT OF HEARING.—Any hear-
5 ing requested under subparagraph (A) shall be
6 conducted before an administrative law judge.
7 If no hearing is so requested, the Secretary’s
8 imposition of the order shall constitute a final
9 and unappealable order.

10 “(C) AUTHORITY IN HEARINGS.—In con-
11 ducting hearings under this paragraph—

12 “(i) agents of the Secretary and ad-
13 ministrative law judges shall have reason-
14 able access necessary to enable such agents
15 and judges to examine evidence of any car-
16 rier, agent, or association or its subsidiary
17 being investigated; and

18 “(ii) administrative law judges, may,
19 if necessary, compel by subpoena the at-
20 tendance of witnesses and the production
21 of evidence at any designated place or
22 hearing.

23 In case of contumacy or refusal to obey a sub-
24 poena lawfully issued under this subparagraph
25 and upon application of the Secretary, an ap-

1 appropriate district court of the United States
2 may issue an order requiring compliance with
3 such subpoena and any failure to obey such
4 order may be punished by such court as a con-
5 tempt thereof.

6 “(D) ISSUANCE OF ORDERS.—If an admin-
7 istrative law judge determines in a hearing
8 under this paragraph, upon the preponderance
9 of the evidence received, that a carrier, agent,
10 or association or its subsidiary named in the
11 complaint has violated the requirements of this
12 title, the administrative law judge shall state
13 the findings of fact and issue and cause to be
14 served on such carrier, agent, association, or
15 subsidiary an order described in paragraph (4).

16 “(4) CEASE AND DESIST ORDER WITH CIVIL
17 MONEY PENALTY.—

18 “(A) IN GENERAL.—Subject to the provi-
19 sions of subparagraphs (B) through (F), an
20 order under this paragraph—

21 “(i) shall require the agent, associa-
22 tion or its subsidiary, or a carrier—

23 “(I) to cease and desist from
24 such violations; and

1 “(II) to pay a civil penalty in an
2 amount not to exceed \$15,000 in the
3 case of each agent, and not to exceed
4 \$25,000 for each association or its
5 subsidiary or a carrier for each such
6 violation; and

7 “(ii) may require the agent, associa-
8 tion or its subsidiary, or a carrier to take
9 such other remedial action as is appro-
10 priate.

11 “(B) CORRECTIONS WITHIN 30 DAYS.—No
12 order shall be imposed under this paragraph by
13 reason of any violation if the carrier, agent, or
14 association or its subsidiary establishes to the
15 satisfaction of the Secretary that—

16 “(i) such violation was due to reason-
17 able cause and was not intentional and was
18 not due to willful neglect; and

19 “(ii) such violation is corrected within
20 the 30-day period beginning on the earliest
21 date the carrier, agent, association, or sub-
22 sidiary knew, or exercising reasonable dili-
23 gence could have known, that such a viola-
24 tion was occurring.

1 “(C) WAIVER BY SECRETARY.—In the case
2 of a violation under this title that is due to rea-
3 sonable cause and not to willful neglect, the
4 Secretary may waive part or all of the civil
5 money penalty imposed under subparagraph
6 (A)(i)(II) to the extent that payment of such
7 penalty would be grossly excessive relative to
8 the violation involved and to the need for deter-
9 rence of violations.

10 “(D) ADMINISTRATIVE APPELLATE RE-
11 VIEW.—The decision and order of an adminis-
12 trative law judge under this paragraph shall be-
13 come the final agency decision and order of the
14 Secretary unless, within 30 days, the Secretary
15 modifies or vacates the decision and order, in
16 which case the decision and order of the Sec-
17 retary shall become a final order under this
18 paragraph.

19 “(E) JUDICIAL REVIEW.—A carrier, agent,
20 or association or its subsidiary or any other in-
21 dividual adversely affected by a final order is-
22 sued under this paragraph may, within 45 days
23 after the date the final order is issued, file a pe-
24 tition in the Court of Appeals for the appro-
25 priate circuit for review of the order.

1 “(F) ENFORCEMENT OF ORDERS.—If a
2 carrier, agent, or association or its subsidiary
3 fails to comply with a final order issued under
4 this paragraph against the carrier, agent, asso-
5 ciation or subsidiary after opportunity for judi-
6 cial review under subparagraph (E), the Sec-
7 retary shall file a suit to seek compliance with
8 the order in any appropriate district court of
9 the United States. In any such suit, the validity
10 and appropriateness of the final order shall not
11 be subject to review.

12 “(d) DEMONSTRATION GRANT PROGRAM.—

13 “(1) IN GENERAL.—The Secretary may award
14 grants to States for the establishment of demonstra-
15 tion programs to improve the enforcement within
16 such States of long-term care insurance standards
17 applicable under this title.

18 “(2) APPLICATION.—To be eligible to receive a
19 grant under paragraph (1), a State shall prepare
20 and submit to the Secretary an application at such
21 time, in such manner, and containing such informa-
22 tion as the Secretary may require, including a de-
23 scription of the program for which the State intends
24 to use the amounts provided under the grant.

1 “(3) MINIMUM AMOUNT OF GRANTS.—The
2 amount of a grant awarded under this subsection
3 shall not be less than \$100,000.

4 “(4) EVALUATION.—A State that receives a
5 grant under this subsection shall comply with such
6 evaluation procedures as the Secretary shall by regu-
7 lation establish. The Secretary shall utilize such
8 evaluations to conduct an overall evaluation of the
9 results of the demonstration programs established
10 under this section.

11 “(5) AUTHORIZATION OF APPROPRIATIONS.—
12 There are authorized to be appropriated to carry out
13 this subsection, \$5,000,000 for each of the fiscal
14 years 1996 through 2000.

15 **“SEC. 2712. REGULATION OF SALES PRACTICES.**

16 “(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

17 “(1) IN GENERAL.—Each agent (as defined in
18 section 2733) or association that is selling or offer-
19 ing for sale a long-term care insurance policy has
20 the duty of good faith and fair dealing to the pur-
21 chaser or potential purchaser of such a policy.

22 “(2) PROHIBITED PRACTICES.—An agent or as-
23 sociation is considered to have violated paragraph
24 (1) if the agent or association engages in any of the
25 following practices:

1 “(A) TWISTING.—

2 “(i) IN GENERAL.—Knowingly making
3 any misleading representation (including
4 the inaccurate completion of medical his-
5 tories) or incomplete or fraudulent com-
6 parison of any long-term care insurance
7 policy or insurers for the purpose of induc-
8 ing, or tending to induce, any person to re-
9 tain or effect a change with respect to a
10 long-term care insurance policy.

11 “(ii) POLICY REPLACEMENT FORM.—

12 With respect to any person who elects to
13 replace or effect a change in a long-term
14 care insurance policy, the individual that is
15 selling such policy shall ensure that such
16 person completes a policy replacement
17 form developed by the NAIC. A copy of
18 such form shall be provided to such person
19 and additional copies shall be delivered by
20 the selling individual to the old policy is-
21 suer and the new issuer and kept on file
22 for inspection by the State regulatory
23 agency.

24 “(B) HIGH PRESSURE TACTICS.—Employ-
25 ing any method of marketing having the effect

1 of, or intending to, induce the purchase of long-
2 term care insurance policy through force, fright,
3 threat or undue pressure, whether explicit or
4 implicit.

5 “(C) COLD LEAD ADVERTISING.—Making
6 use directly or indirectly of any method of mar-
7 keting which fails to disclose in a conspicuous
8 manner that a purpose of the method of mar-
9 keting is solicitation of insurance and that con-
10 tact will be made by an insurance agent or in-
11 surance company.

12 “(D) OTHERS.—Engaging in such other
13 practices determined inappropriate under guide-
14 lines issued by the NAIC.

15 “(b) FINANCIAL STANDARDS.—The NAIC shall de-
16 velop recommended financial minimum standards (includ-
17 ing both income and asset criteria) for the purpose of ad-
18 vising individuals considering the purchase of a long-term
19 care insurance policy.

20 “(c) PROHIBITION OF SALE OR ISSUANCE TO MEDIC-
21 AID BENEFICIARIES.—An agent, an association, or a car-
22 rier may not knowingly sell or issue a long-term care in-
23 surance policy to an individual who is eligible for medical
24 assistance under title XIX of the Social Security Act.

1 “(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLI-
 2 CATE SERVICE BENEFIT POLICIES.—An agent, associa-
 3 tion or its subsidiary, or a carrier may not sell or issue
 4 a service-benefit long-term care insurance policy to an in-
 5 dividual—

6 “(1) knowing that the policy provides for cov-
 7 erage that duplicates coverage already provided in
 8 another service-benefit long-term care insurance pol-
 9 icy held by such individual (unless the policy is in-
 10 tended to replace such other policy); or

11 “(2) for the benefit of an individual unless the
 12 individual (or a representative of the individual) pro-
 13 vides a written statement to the effect that the cov-
 14 erage—

15 “(A) does not duplicate other coverage in
 16 effect under a service-benefit long-term care in-
 17 surance policy; or

18 “(B) will replace another service-benefit
 19 long-term care insurance policy.

20 In this subsection, the term ‘service-benefit long-term care
 21 insurance policy’ means a long-term care insurance policy
 22 which provides for benefits based on the type and amount
 23 of services furnished.

24 “(e) PROHIBITION BASED ON ELIGIBILITY FOR
 25 OTHER BENEFITS.—A carrier may not sell or issue a

1 long-term care insurance policy that reduces, limits or co-
2 ordinates the benefits provided under the policy on the
3 basis that the policyholder has or is eligible for other long-
4 term care insurance coverage or benefits.

5 “(f) PROVISION OF OUTLINE OF COVERAGE.—No
6 agent, association or its subsidiary, or carrier may sell or
7 offer for a sale a long-term care insurance policy (or for
8 a certificate under a group long-term care insurance pol-
9 icy) without providing to the purchaser or potential pur-
10 chaser (or representative) an outline of coverage that com-
11 plies with the standards established under section
12 2701(a).

13 “(g) PENALTIES.—Any agent who sells, offers for
14 sale, or issues a long-term care insurance policy in viola-
15 tion of this section may be imprisoned not more than 5
16 years, or fined in accordance with title 18, United States
17 Code, and, in addition, is subject to a civil money penalty
18 of not to exceed \$15,000 for each such violation. Any asso-
19 ciation or its subsidiary or carrier that sells, offers for
20 sale, or issues a long-term care insurance policy in viola-
21 tion of this section may be fined in accordance with title
22 18, United States Code, and in addition, is subject to a
23 civil money penalty of not to exceed \$25,000 for each vio-
24 lation.

1 “(h) AGENT TRAINING AND CERTIFICATION RE-
2 QUIREMENTS.—The NAIC, shall establish requirements
3 for long-term care insurance agent training and certifi-
4 cation that—

5 “(1) specify requirements for training insurance
6 agents who desire to sell or offer for sale long-term
7 care insurance policies; and

8 “(2) specify procedures for certifying agents
9 who have completed such training and who are as
10 qualified to sell or offer for sale long-term care in-
11 surance policies.

12 **“SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CAR-**
13 **RIERS.**

14 “(a) REFUND OF PREMIUMS.—If an application for
15 a long-term care insurance policy (or for a certificate
16 under a group long-term care insurance policy) is denied
17 or an applicant returns a policy or certificate within 30
18 days of the date of its issuance pursuant to subsection
19 2717, the carrier shall refund directly to the applicant,
20 or in the case of an employer to whomever remits the pre-
21 mium, and not by delivery by the agent, not later than
22 30 days after the date of the denial or return, any pre-
23 miums paid with respect to such a policy (or certificate).

24 “(b) MAILING OF POLICY.—If an application for a
25 long-term care insurance policy (or for a certificate under

1 a group long-term care insurance policy) is approved, the
2 carrier shall provide the applicant, or in the case of a
3 group plan the employer, the policy (or certificate) of in-
4 surance not later than 30 days after the date of the ap-
5 proval.

6 “(c) INFORMATION ON DENIALS OF CLAIMS.—If a
7 claim under a long-term care insurance policy is denied,
8 the carrier shall, within 30 days of the date of a written
9 request by the policyholder or certificate holder (or rep-
10 resentative)—

11 “(1) provide a written explanation of the rea-
12 sons for the denial; and

13 “(2) make available all medical and patient
14 records directly relating to such denial.

15 Except as provided in subsection (e) of section 2715, no
16 claim under such a policy may be denied on the basis of
17 a failure to disclose a condition at the time of issuance
18 of the policy if the application for the policy failed to re-
19 quest information respecting the condition.

20 “(d) REPORTING OF INFORMATION.—A carrier that
21 issues one or more long-term care insurance policies shall
22 periodically (not less often than annually) report, in a
23 form and in a manner determined by the NAIC, to the
24 Commissioner, superintendent or director of insurance of
25 each State in which the policy is delivered, and shall make

1 available to the Secretary, upon request, information in
2 a form and manner determined by the NAIC concerning—

3 “(1) the long-term care insurance policies of the
4 carrier that are in force;

5 “(2) the most recent premiums for such policies
6 and the premiums imposed for such policies since
7 their initial issuance;

8 “(3) the lapse rate, replacement rate, and re-
9 scission rates by policy;

10 “(4) the names of that 10 percent of its agents
11 that—

12 “(A) have the greatest lapse and replace-
13 ment rate; and

14 “(B) have produced at least \$50,000 of
15 long-term care insurance sales in the previous
16 year; and

17 “(5) the claims denied (expressed as a number
18 and as a percentage of claims submitted) by policy.

19 Information required under this subsection shall be re-
20 ported in a format specified in the standards established
21 under section 2701(a). For purposes of paragraph (3),
22 there shall be included (but reported separately) data con-
23 cerning lapses due to the death of the policyholder. For
24 purposes of paragraph (4), there shall not be included as
25 a claim any claim that is denied solely because of the fail-

1 ure to meet a deductible, waiting period, or exclusionary
2 period.

3 “(e) STANDARDS ON COMPENSATION FOR SALE OF
4 POLICIES.—

5 “(1) IN GENERAL.—A carrier that issues one or
6 more long-term care insurance policies may provide
7 a commission or other compensation to an agent or
8 other representative for the sale of such a policy only
9 if the first year commission or other first year com-
10 pensation to be paid does not exceed 200 percent of
11 the commission or other compensation paid for sell-
12 ing or servicing the policy in the second year, or if
13 the first year commission or other compensation to
14 be paid does not exceed 50 percent of the premium
15 paid on the first year policy, until the NAIC promul-
16 gates mandatory standards concerning compensation
17 for the sale of such policies.

18 “(2) SUBSEQUENT YEARS.—The commission or
19 other compensation provided for the sale of long-
20 term care insurance policies in years subsequent to
21 the first year of the policy shall be the same as that
22 provided in the second subsequent year and shall be
23 provided for no fewer than 5 subsequent years.

24 “(3) LIMITATION.—No carrier shall provide
25 compensation to its agents for the sale of a long-

term care insurance policy and no agent shall receive compensation greater than the renewal compensation payable by the replacing carrier on renewal policies if an existing policy is replaced.

“(4) COMPENSATION DEFINED.—As used in this subsection, the term ‘compensation’ includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, including but not limited to deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

**“SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE,
AND BASIS FOR CANCELLATION OF POLICIES.**

“(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

**“(b) CONTINUATION AND CONVERSION RIGHTS FOR
GROUP POLICIES.—**

“(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

“(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains cov-

1 erage under the existing group policy when such cov-
2 erage would otherwise terminate and which is sub-
3 ject only to the continued timely payment of pre-
4 mium when due. A group policy which restricts pro-
5 vision of benefits and services to or contains incen-
6 tives to use certain providers or facility, may provide
7 continuation benefits which are substantially equiva-
8 lent to the benefits of the existing group policy.

9 “(3) BASIS FOR CONVERSION.—For purposes of
10 paragraph (1), a policy provides a basis for conver-
11 sion of coverage if the policy entitles each individ-
12 ual—

13 “(A) whose coverage under the group pol-
14 icy would otherwise be terminated for any rea-
15 son; and

16 “(B) who has been continuously insured
17 under the policy (or group policy which was re-
18 placed) for at least 6 months before the date of
19 the termination;

20 to issuance of a policy providing benefits identical to,
21 substantially equivalent to, or in excess of, those of
22 the policy being terminated, without evidence of in-
23 surability.

24 “(4) TREATMENT OF SUBSTANTIAL EQUIVA-
25 LENCE.—In determining under this subsection

1 whether benefits are substantially equivalent, consid-
2 eration should be given to the difference between
3 managed care and non-managed care plans.

4 “(5) GROUP REPLACEMENT OF POLICIES.—If a
5 group long-term care insurance policy is replaced by
6 another long-term care insurance policy purchased
7 by the same policyholder, the succeeding issuer shall
8 offer coverage to all persons covered under the old
9 group policy on its date of termination. Coverage
10 under the new group policy shall not result in any
11 exclusion for preexisting conditions that would have
12 been covered under the group policy being replaced.

13 “(c) STANDARDS FOR ISSUANCE.—

14 “(1) IN GENERAL.—

15 “(A) GUARANTEE.—An agent, association
16 or carrier that sells or issues long-term care in-
17 surance policies shall guarantee that such poli-
18 cies shall be sold or issued to an individual, or
19 eligible individual in the case of a group plan,
20 if such individual meets the minimum medical
21 underwriting requirements of such policy.

22 “(B) PREMIUM FOR CONVERTED POL-
23 ICY.—If a group policy from which conversion
24 is made is a replacement for a previous group
25 policy, the premium for the converted policy

1 shall be calculated on the basis of the insured's
2 age at the inception of coverage under the
3 group policy from which conversion is made.

4 Where the group policy from which conversion
5 is made replaced previous group coverage, the
6 premium for the converted policy shall be cal-
7 culated on the basis of the insured's age at in-
8 ception of coverage under the group policy re-
9 placed.

10 “(2) UPGRADE FOR CURRENT POLICIES.—The
11 NAIC shall establish standards, including those pro-
12 viding guidance on medical underwriting and age
13 rating, with respect to the access of individuals to
14 policies offering upgraded benefits.

15 “(d) EFFECT OF INCAPACITATION.—

16 “(1) IN GENERAL.—

17 “(A) PROHIBITION.—Except as provided
18 in paragraph (2), a long-term care insurance
19 policy in effect as of the effective date of the
20 standards established under section 2701(a)
21 may not be canceled for nonpayment if the pol-
22 icy holder is determined by a long-term care
23 provider, physician or other health care pro-
24 vider, independent of the issuer of the policy, to

1 be cognitively or mentally incapacitated so as to
2 not make payments in a timely manner.

3 “(B) REINSTATEMENT.—A long-term care
4 policy shall include a provision that provides for
5 the reinstatement of such coverage, in the event
6 of lapse, if the insurer is provided with proof of
7 cognitive or mental incapacitation. Such rein-
8 statement option shall remain available for a
9 period of not less than 5 months after termi-
10 nation and shall allow for the collection of past
11 due premium.

12 “(2) PERMITTED CANCELLATION.—A long-term
13 care insurance policy may be canceled under para-
14 graph (1) for nonpayment if—

15 “(A) the period of such nonpayment is in
16 excess of 30 days; and

17 “(B) notice of intent to cancel is provided
18 to the policyholder or designated representative
19 of the policy holder not less than 30 days prior
20 to such cancellation, except that notice may not
21 be provided until the expiration of 30 days after
22 a premium is due and unpaid.

23 Notice under this paragraph shall be deemed to have
24 been given as of 5 days after the mailing date.

1 **"SEC. 2715. BENEFIT STANDARDS.**

2 “(a) USE OF STANDARD DEFINITIONS AND TERMI-
3 NOLOGY, UNIFORM FORMAT, AND STANDARD BENE-
4 FITS.—Each long-term care insurance policy shall, with
5 respect to services, providers or facilities, pursuant to
6 standards established under section 2701(a)—

7 “(1) use uniform language and definitions, ex-
8 cept that such language and definitions may take
9 into account the differences between States with re-
10 spect to definitions and terminology used for long-
11 term care services and providers;

12 “(2) use a uniform format for presenting the
13 outline of coverage under such a policy; and

14 “(3) provide coverage for at least one standard
15 benefits package (of those developed by the NAIC)
16 that shall include the limitations on the amount of
17 payments per day and the lengths of covered stays
18 for nursing facility and home health care services;
19 as prescribed under guidelines issued by the NAIC and
20 periodically updated.

21 “(b) DISCLOSURE.—

22 “(1) OUTLINE OF COVERAGE.—

23 “(A) REQUIREMENT.—Each carrier that
24 sells or offers for sale a long-term care insur-
25 ance policy shall provide an outline of coverage
26 under such policy that meets the applicable

standards established pursuant to section 2701(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the NAIC and periodically updated.

“(B) CONTENTS.—The outline of coverage for each long-term care insurance policy shall include at least the following:

“(i) A description of the principal benefits and coverage under the policy.

“(ii) A statement of the principal exclusions, reductions, and limitations contained in the policy.

“(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

“(iv) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) con-

1 tains the contractual provisions that gov-
2 ern, except that such summary shall sub-
3 stantially and accurately reflect the con-
4 tents of the policy or the master policy.

5 “(v) A description of the terms, speci-
6 fied in section 2717, under which a policy
7 or certificate may be returned and pre-
8 mium refunded.

9 “(vi) Information on national average
10 costs for nursing facility and home health
11 care and information (in graphic form) on
12 the relationship of the value of the benefits
13 provided under the policy to such national
14 average costs and State average costs,
15 where available.

16 “(vii) A statement of the percentage
17 limit on annual premium increases that is
18 provided under the policy pursuant to this
19 section.

20 “(2) CERTIFICATES.—A certificate issued pur-
21 suant to a group long-term care insurance policy
22 shall include—

23 “(A) a description of the principal benefits
24 and coverage provided in the policy;

1 “(B) a statement of the principal exclu-
2 sions, reductions, and limitations contained in
3 the policy; and

4 “(C) a statement that the group master
5 policy determines governing contractual provi-
6 sions.

7 “(3) LONG-TERM CARE AS PART OF LIFE IN-
8 SURANCE.—In the case of a long-term care insur-
9 ance policy issued as a part of, or a rider on, a life
10 insurance policy, at the time of policy delivery there
11 shall be provided a policy summary that includes—

12 “(A) an explanation of how the long-term
13 care benefits interact with other components of
14 the policy (including deductions from death
15 benefits);

16 “(B) an illustration of the amount of bene-
17 fits, the length of benefit, and the guaranteed
18 lifetime benefits (if any) for each covered per-
19 son; and

20 “(C) any exclusions, reductions, and limi-
21 tations on benefits of long-term care.

22 “(4) ADDITIONAL INFORMATION.—The NAIC
23 shall develop recommendations with respect to in-
24 forming consumers of the long-term economic viabil-

ity of carriers issuing long-term care insurance policies.

“(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.—

“(1) IN GENERAL.—A long-term care insurance policy may not condition or limit eligibility—

“(A) for benefits for a type of services to the need for or receipt of any other services;

“(B) for any benefit on the medical necessity for such benefit;

“(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC; or

“(D) for residential care (if covered under the policy) only—

“(i) to care provided in facilities which provide a higher level of care; or

“(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

1 “(2) HOME HEALTH CARE OR COMMUNITY-
2 BASED SERVICES.—If a long-term care insurance
3 policy provides benefits for the payment of specified
4 home health care or community-based services, the
5 policy—

6 “(A) may not limit such benefits to serv-
7 ices provided by registered nurses or licensed
8 practical nurses;

9 “(B) may not require benefits for such
10 services to be provided by a nurse or therapist
11 that can be provided by a home health aide or
12 licensed or certified home care worker, except
13 that if no State licensure or certification laws
14 exists, in compliance with qualifications devel-
15 oped by the NAIC;

16 “(C) may not limit such benefits to serv-
17 ices provided by agencies or providers certified
18 under title XVIII of the Social Security Act;
19 and

20 “(D) must provide, at a minimum, benefits
21 for personal care services (including home
22 health aide and home care worker services as
23 defined by the NAIC) home health services,
24 adult day care, and respite care in an individ-
25 ual’s home or in another setting in the commu-

nity, or any of these benefits on a respite care basis.

“(3) NURSING FACILITY SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act or until such time as subsequently provided for by the NAIC in establishing uniform language and definitions under section 2715(a)(1)) in the State.

“(4) PER DIEM POLICIES.—

“(A) DEFINITION.—For purposes of this title, the term ‘per diem long-term care insurance policy’ means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

“(B) LIMITATION.—No per diem long-term care insurance policy (or certificate) may condition or otherwise exclude benefit payments

1 based on the receipt of any type of nursing fa-
2 cility, home health care or community-based
3 services.

4 “(d) PROHIBITION OF DISCRIMINATION.—A long-
5 term care insurance policy may not treat benefits under
6 the policy in the case of an individual with Alzheimer’s
7 disease, with any related progressive degenerative demen-
8 tia of an organic origin, with any organic or inorganic
9 mental illness, or with mental retardation or any other
10 cognitive or mental impairment differently from an indi-
11 vidual having another medical condition for which benefits
12 may be made available.

13 “(e) LIMITATION ON USE OF PREEXISTING CONDI-
14 TION LIMITS.—

15 “(1) INITIAL ISSUANCE.—

16 “(A) IN GENERAL.—Subject to subpara-
17 graph (B), a long-term care insurance policy
18 may not exclude or condition benefits based on
19 a medical condition for which the policyholder
20 received treatment or was otherwise diagnosed
21 before the issuance of the policy.

22 “(B) 6-MONTH LIMIT.—

23 “(i) IN GENERAL.—No long-term care
24 insurance policy or certificate issued under
25 this title shall utilize a definition of ‘pre-

existing condition' that is more restrictive than the following: The term 'preexisting condition' means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured individual.

"(ii) PROHIBITION ON EXCLUSION OF COVERAGE.—No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of the coverage of the insured individual.

"(2) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

"(f) ELIGIBILITY FOR BENEFITS.—

1 “(1) LONG-TERM CARE POLICIES.—Each long-
2 term care insurance policy shall—

3 “(A) describe the level of benefits available
4 under the policy; and

5 “(B) specify in clear, understandable
6 terms, the level (or levels) of physical, cognitive,
7 or mental impairment required in order to re-
8 ceive benefits under the policy.

9 “(2) FUNCTIONAL ASSESSMENT.—In order to
10 submit a claim under any long-term care insurance
11 policy, each claimant shall have a professional func-
12 tional assessment of his or her physical, cognitive,
13 and mental abilities. Such initial assessment shall be
14 conducted by an individual or entity, meeting the
15 qualifications established by the NAIC to assure the
16 professional competence and credibility of such indi-
17 vidual or entity and that such individual meets any
18 applicable State licensure and certification require-
19 ments. The individual or entity conducting such as-
20 sessment may not control, or be controlled by, the
21 issuer of the policy. For purposes of this paragraph
22 and paragraph (4), the term ‘control’ means the di-
23 rect or indirect possession of the power to direct the
24 management and policies of a person. Control is pre-
25 sumed to exist, if any person directly or indirectly,

owns, controls, holds with the power to vote, or holds proxies representing 10 percent of the voting securities of another person.

“(3) CLAIMS REVIEW.—Except as provided in paragraph (4), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

“(4) APPEALS PROCESS.—

“(A) IN GENERAL.—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards established by the NAIC, for individuals who dispute the results of the claims review, conducted under paragraph (3), of the claimant’s functional assessment, conducted under paragraph (2).

“(B) INDEPENDENT ASSESSMENT.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant’s physical, cognitive or mental abilities.

“(C) CONDUCT.—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the

1 qualifications established by the NAIC to as-
2 sure the professional competence and credibility
3 of such individual or entity and any applicable
4 State licensure and certification requirements
5 and may not be conducted—

6 “(i) by an individual who has a direct
7 or indirect significant or controlling inter-
8 est in, or direct affiliation or relationship
9 with, the issuer of the policy;

10 “(ii) by an entity that provides serv-
11 ices to the policyholder or certificateholder
12 for which benefits are available under the
13 long-term care insurance policy; or

14 “(iii) by an individual or entity in con-
15 trol of, or controlled by, the issuer of the
16 policy.

17 “(5) STANDARD ASSESSMENTS.—Not later than
18 2 years after the date of enactment of this title, the
19 advisory committee established under section
20 2701(d) shall recommend uniform needs assessment
21 mechanisms for the determination of eligibility for
22 benefits under such assessments.

23 “(g) INFLATION PROTECTION.—

24 “(1) OPTION TO PURCHASE.—A carrier may
25 not offer a long-term care insurance policy unless

1 the carrier also offers to the proposed policyholder,
2 including each group policyholder, the option to pur-
3 chase a policy that provides for increases in benefit
4 levels, with benefit maximums or reasonable dura-
5 tions that are meaningful, to account for reasonably
6 anticipated increases in the costs of long-term care
7 services covered by the policy. A carrier may not
8 offer to a policyholder an inflation protection feature
9 that is less favorable to the policyholder than one of
10 the following:

11 “(A) With respect to policies that provide
12 for automatic periodic increases in benefits, the
13 policy provides for an annual increase in bene-
14 fits in a manner so that such increases are
15 computed annually at a rate of not less than 5
16 percent.

17 “(B) With respect to policies that provide
18 for periodic opportunities to elect an increase in
19 benefits, the policy guarantees that the insured
20 individual will have the right to periodically in-
21 crease the benefit levels under the policy with-
22 out providing evidence of insurability or health
23 status so long as the option for the previous pe-
24 riod was not declined. The amount of any such

1 additional benefit may not be less than the dif-
2 ference between—

3 “(i) the existing policy benefit; and

4 “(ii) such existing benefit compounded
5 annually at a rate of at least 5 percent for
6 the period beginning on the date on which
7 the existing benefit is purchased and ex-
8 tending until the year in which the offer of
9 increase is made.

10 “(C) With respect to service benefit poli-
11 cies, the policy covers a specified percentage of
12 the actual or reasonable charges and does not
13 include a maximum specified indemnity amount
14 or limit.

15 “(2) EXCEPTION.—The requirements of para-
16 graph (1) shall not apply to life insurance policies or
17 riders containing accelerated long-term care benefits.

18 “(3) REQUIRED INFORMATION.—Carriers shall
19 include the following information in or together with
20 the outline of coverage provided under this title:

21 “(A) A graphic comparison of the benefit
22 levels of a policy that increases benefits over the
23 policy period with a policy that does not in-
24 crease benefits. Such comparison shall show

benefit levels over not less than a 20-year period.

“(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

“(4) CONTINUATION OF PROTECTION.—Inflation protection benefit increases under this subsection under a policy that contains such protection shall continue without regard to an insured’s age, claim status or claim history, or the length of time the individual has been insured under the policy.

“(5) CONSTANT PREMIUM.—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

“(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care

1 insurance policy unless a carrier obtains a written
2 rejection of such protection signed by the policy-
3 holder.

4 **“SEC. 2716. NONFORFEITURE.**

5 “(a) IN GENERAL.—Each long-term care insurance
6 policy (or certificate) shall provide that if the policy lapses
7 after the policy has been in effect for a minimum period
8 (specified under the standards under section 2701(a)), the
9 policy will provide, without payment of any additional pre-
10 miums, nonforfeiture benefits as determined appropriate
11 by the NAIC.

12 “(b) ESTABLISHMENT OF STANDARDS.—The stand-
13 ards under section 2701(a) shall provide that the percent-
14 age or amount of benefits under subsection (a) must in-
15 crease based upon the policyholder’s equity in the policy.

16 **“SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND**
17 **RIGHT TO RETURN.**

18 “(a) CONTESTABILITY.—A carrier may not cancel or
19 renew a long-term care insurance policy or deny a claim
20 under the policy based on fraud or material misrepresenta-
21 tion relating to the issuance of the policy unless notice
22 of such fraud or material misrepresentation is provided
23 within a time period to be determined by the NAIC.

24 “(b) RIGHT TO RETURN.—Each applicant for a long-
25 term care insurance policy shall have the right to return

1 the policy (or certificates) within 30 days of the date of
2 its delivery (and to have the premium refunded) if, after
3 examination of the policy or certificate, the applicant is
4 not satisfied for any reason.

5 **“SEC. 2718. CIVIL MONEY PENALTY.**

6 “(a) CARRIER.—Any carrier, association or its sub-
7 sidiary that sells or offers for sale a long-term care insur-
8 ance policy and that—

9 “(1) fails to make a refund in accordance with
10 section 2713(a);

11 “(2) fails to transmit a policy in accordance
12 with section 2713(b);

13 “(3) fails to provide, make available, or report
14 information in accordance with subsection (c) or (d)
15 of section 2713;

16 “(4) provides a commission or compensation in
17 violation of section 2713(e);

18 “(5) fails to provide an outline of coverage in
19 violation of section 2715(b)(1); or

20 “(6) issues a policy without obtaining certain
21 information in violation of section 2715(f);

22 is subject to a civil money penalty of not to exceed \$25,000
23 for each such violation.

24 “(b) AGENTS.—Any agent that sells or offers for sale
25 a long-term care insurance policy and that—

1 “(1) fails to make a refund in accordance with
2 section 2713(a);

3 “(2) fails to transmit a policy in accordance
4 with section 2713(b);

5 “(3) fails to provide, make available, or report
6 information in accordance with subsection (c) or (d)
7 of section 2713;

8 “(4) fails to provide an outline of coverage in
9 violation of section 2715(b)(1); or

10 “(5) issues a policy without obtaining certain
11 information in violation of section 2715(f);
12 is subject to a civil money penalty of not to exceed \$15,000
13 for each such violation.

14 “PART C—LONG-TERM CARE INSURANCE POLICIES,
15 DEFINITION AND ENDORSEMENTS

16 "SEC. 2721. LONG-TERM CARE INSURANCE POLICY DE-
17 FINED.

18 “(a) IN GENERAL.—As used in this section, the term
19 ‘long-term care insurance policy’ means any insurance pol-
20 icy, rider or certificate advertised, marketed, offered or de-
21 signed to provide coverage for not less than 12 consecutive
22 months for each covered person on an expense incurred,
23 indemnity prepaid or other basis, for one or more nec-
24 essary diagnostic, preventive, therapeutic, rehabilitative,
25 maintenance or personal care services, provided in a set-

1 ting other than an acute care unit of a hospital. Such term
2 includes—

3 “(1) group and individual annuities and life in-
4 surance policies, riders or certificates that provide
5 directly, or that supplement long-term care insur-
6 ance; and

7 “(2) a policy, rider or certificates that provides
8 for payment of benefits based on cognitive impair-
9 ment or the loss of functional capacity.

10 “(b) ISSUANCE.—Long-term care insurance policies
11 may be issued by—

12 “(1) carriers;

13 “(2) fraternal benefit societies;

14 “(3) nonprofit health, hospital, and medical
15 service corporations;

16 “(4) prepaid health plans;

17 “(5) health maintenance organizations; or

18 “(6) any similar organization to the extent they
19 are otherwise authorized to issue life or health insur-
20 ance.

21 “(c) POLICIES EXCLUDED.—The term ‘long-term
22 care insurance policy’ shall not include any insurance pol-
23 icy, rider or certificate that is offered primarily to provide
24 basic Medicare supplement coverage, basic hospital ex-
25 pense coverage, basic medical-surgical expense coverage,

1 hospital confinement indemnity coverage, major medical
2 expense coverage, disability income or related asset-protec-
3 tion coverage, accident only coverage, specified disease or
4 specified accident coverage, or limited benefit health cov-
5 erage. With respect to life insurance, such term shall not
6 include life insurance policies, riders or certificates that
7 accelerate the death benefit specifically for one or more
8 of the qualifying events of terminal illness, medical condi-
9 tions requiring extraordinary medical intervention, or per-
10 manent institutional confinement, and that provide the op-
11 tion of a lump-sum payment for those benefits and in
12 which neither the benefits nor the eligibility for the bene-
13 fits is conditioned upon the receipt of long-term care.

14 “(d) APPLICATIONS.—Notwithstanding any other
15 provision of this title, this title shall apply to any product
16 advertised, marketed or offered as a long-term insurance
17 policy, rider or certificate.

18 **“SEC. 2722. CODE OF CONDUCT WITH RESPECT TO EN-**
19 **DORSEMENTS.**

20 “Not later than 1 year after the date of enactment
21 of this title the NAIC shall issue guidelines that shall
22 apply to organizations and associations, other than em-
23 ployers and labor organizations that do not accept com-
24 pensation, and their subsidiaries that provide endorse-
25 ments of long-term care insurance policies, or that permit

1 such policies to be offered for sale through the organiza-
2 tion or association. Such guidelines shall include at mini-
3 mum the following:

4 “(1) In endorsing or selling long-term care in-
5 surance policies, the primary responsibility of an or-
6 ganization or association shall be to educate their
7 members concerning such policies and assist such
8 members in making informed decisions. Such organi-
9 zations and associations may not function primarily
10 as sales agents for insurance companies.

11 “(2) Organizations and associations shall pro-
12 vide objective information regarding long-term care
13 insurance policies sold or endorsed by such organiza-
14 tions and associations to ensure that members of
15 such organizations and associations have a balanced
16 and complete understanding of both the strengths
17 and weaknesses of the policies that are being en-
18 dored or sold.

19 “(3) Organizations and associations selling or
20 endorsing long-term care insurance policies shall dis-
21 close in marketing literature provided to their mem-
22 bers concerning such policies the manner in which
23 such policies and the insurance company issuing
24 such policies were selected. If the organization or as-
25 sociation and the insurance company have interlock-

ing directorates, the organization or association shall disclose such fact to their members.

“(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) from the endorsement or sale of the policy to its members.

“(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

“PART D—MISCELLANEOUS PROVISIONS

**“SEC. 2731. FUNDING FOR LONG-TERM CARE INSURANCE
INFORMATION, COUNSELING, AND ASSIST-
ANCE.**

“(a) IN GENERAL.—The Secretary, acting through the Public Health Service, may award grants to States, and national organizations with demonstrated experience

1 in long-term care insurance, for the establishment of pro-
 2 grams to provide information, counseling, and assistance
 3 relating to the procurement of adequate and appropriate
 4 long-term care insurance.

5 “(b) APPLICATION.—To be eligible to receive a grant
 6 under subsection (a), a State or national organization
 7 shall prepare and submit to the Secretary an application
 8 at such time, in such manner, and containing such infor-
 9 mation as the Secretary may require, including a descrip-
 10 tion of the program for which the State or organization
 11 intends to use the amounts provided under the grant.

12 “(c) AUTHORIZATION OF APPROPRIATIONS.—

13 “(1) IN GENERAL.—There are authorized to be
 14 appropriate for grants to States under subsection
 15 (a), \$10,000,000 for each of the fiscal years 1996
 16 through 1998.

17 “(2) NATIONAL ORGANIZATIONS.—There are
 18 authorized to be appropriate for grants to national
 19 organizations under subsection (a), \$1,000,000 for
 20 each of the fiscal years 1996 through 1998.

21 **“SEC. 2732. DEFINITIONS.**

22 “As used in this title:

23 “(1) AGENT.—The term ‘agent’ means—

24 “(A) prior to 2 years after the date of en-
 25 actment of this Act, an individual who sells or

1 offers for sale a long-term care insurance policy
2 subject to the requirements of this title and is
3 licensed or required to be licensed under State
4 law for such purpose; and

5 “(B) after the date referred to in subpara-
6 graph (A), an individual who meets the training
7 and certification requirements established under
8 section 2712(f).

9 “(2) ASSOCIATION.—The term ‘association’ in-
10 cludes the association and its subsidiaries.

11 “(3) CARRIER.—The term ‘carrier’ means any
12 person that offers a health benefit plan, whether
13 through insurance or otherwise, including a licensed
14 insurance company, a prepaid hospital or medical
15 service plan, a health maintenance organization, a
16 self-insured carrier, a reinsurance carrier, and a
17 multiple employer welfare arrangement (a combina-
18 tion of employers associated for the purpose of pro-
19 viding health benefit plan coverage for their employ-
20 ees).”.

21 (b) CONFORMING AMENDMENTS.—

22 (1) Sections 2701 through 2714 of the Public
23 Health Service Act (42 U.S.C. 300cc through
24 300cc-15) are redesignated as sections 2801
25 through 2814, respectively.

(2) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are amended by striking “2701” each place that such appears and inserting “2801”.

Subtitle C—Protection of Assets Under Medicaid Through Use of Qualified Long-term Care Insurance

SEC. 3201. PROTECTION OF ASSETS THROUGH USE OF QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by sections 1601(a) and 1701(a), is amended—

(1) by redesignating section 1933 as section 1934; and

(2) by inserting after section 1932 the following new section:

“SPECIAL RULES FOR ASSET DISREGARD IN THE CASE OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS

“SEC. 1933. (a) IN GENERAL.—Each State plan under this title may provide, subject to subsection (d), that in determining the eligibility of an individual for medical assistance under the plan with respect to such services there shall be disregarded some or all of the individual’s assets which are attributable (as determined under sub-

1 section (c)(2)) to coverage under a qualified long-term
2 care insurance contract (as defined in subsection (b)).

3 “(b) QUALIFIED LONG-TERM CARE INSURANCE
4 CONTRACT DEFINED.—In this section, the term ‘qualified
5 long-term care insurance contract’ means, with respect to
6 a State, a long-term care insurance contract (as defined
7 in section 818A(b) of the Internal Revenue Code of 1986)
8 which—

9 “(1) provides such protection against the costs
10 of receiving long-term care services as the State may
11 require by law;

12 “(2) provides that benefits under the contract
13 shall be paid without regard to eligibility for medical
14 assistance under this title; and

15 “(3) meets such other requirements (such as re-
16 quirements relating to premiums, disclosure, mini-
17 mum benefits, rights of conversion, and standards
18 for claims processing) as the State may determine to
19 be appropriate.

20 “(c) OTHER DEFINITIONS.—In this section:

21 “(1) LONG-TERM CARE SERVICES.—The term
22 ‘long-term care services’ means nursing facility serv-
23 ices, home health care services, and home and com-
24 munity-based services, and includes such other simi-

1 lar items and services described in section 1905(a)
2 as a State may specify.

3 “(2) **ATTRIBUTION RULES.**—An individual’s as-
4 sets are considered to be ‘attributable’ to a qualified
5 long-term care insurance contract to the extent spec-
6 ified under the State plan. Such a plan shall provide
7 for at least one of the following:

8 “(A) All assets are considered attributable
9 if the insurance contract provides coverage for
10 at least a specified period of coverage (of not
11 less than 3 years and of not more than 6 years)
12 for long-term care services.

13 “(B) An amount of assets, up to the dollar
14 limitation on benefits for long-term care serv-
15 ices under the contract, is considered attrib-
16 utable to the contract.

17 “(d) **LIMITATION.**—In no case shall this section re-
18 sult in (1) the total Federal payments to the State for
19 the quarter under this title (including payments attrib-
20 utable to this section), exceeding (2) the total Federal pay-
21 ments that the Secretary estimates would have been paid
22 under this title to the State for the quarter if the State
23 did not provide for the determination of eligibility in ac-
24 cordance with subsection (a).”.

1 (b) CONFORMING AMENDMENT.—Section
2 1902(a)(17)(A) of such Act (42 U.S.C. 1396a(a)(17)(A))
3 is amended by inserting “and section 1932” after “objec-
4 tives of this title”.

5 (c) EFFECTIVE DATE.—

6 (1) IN GENERAL.—The amendments made by
7 this section shall apply (except as provided under
8 paragraph (2)) to payments to States under title
9 XIX of the Social Security Act for calendar quarters
10 beginning on or after one year after the date of the
11 enactment of this Act, without regard to whether
12 regulations to implement such amendment are pro-
13 mulgated by such date.

14 (2) DELAY PERMITTED IF STATE LEGISLATION
15 REQUIRED.—In the case of a State plan for medical
16 assistance under title XIX of the Social Security Act
17 which the Secretary of Health and Human Services
18 determines requires State legislation (other than leg-
19 islation authorizing or appropriating funds) in order
20 for the plan to meet the additional requirements im-
21 posed by the amendments made by this section, the
22 State plan shall not be regarded as failing to comply
23 with the requirements of such title solely on the
24 basis of its failure to meet these additional require-
25 ments before the first day of the first calendar quar-

ter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle D—Studies

SEC. 3301. FEASIBILITY OF ENCOURAGING HEALTH CARE PROVIDERS TO DONATE SERVICES TO HOME-BOUND PATIENTS.

The Comptroller General of the United States shall conduct a study on the feasibility of encouraging health care providers to donate their services to homebound patients. Such study shall include an examination of the effects of qualifying such services as a charitable contribution.

SEC. 3302. FEASIBILITY OF TAX CREDIT FOR HEADS OF HOUSEHOLDS WHO CARE FOR ELDERLY FAMILY MEMBERS IN THEIR HOMES.

The Comptroller General of the United States shall conduct a study on the feasibility of providing heads of households who care for elderly family members in their homes with a tax credit. Such study shall estimate the cost of such a tax credit which would apply to expenses

1 incurred in the custodial care of such an elderly family
2 member to the extent such expenses exceed 5 percent of
3 adjusted gross income.

4 **SEC. 3303. CASE MANAGEMENT OF CURRENT LONG-TERM**
5 **CARE BENEFITS.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall conduct a study of the feasibility
8 of encouraging or requiring the use of a single designated
9 public or nonprofit agency (such as an area agency on
10 aging) to coordinate, through case management, the provi-
11 sion of long-term care benefits under current Federal,
12 State, and local programs in a geographic area.

13 (b) REPORT.—The Secretary shall submit to Con-
14 gress a report on the study conducted under subsection
15 (a) by not later than 1 year after the date of the enact-
16 ment of this Act. Such report shall include such rec-
17 ommendations regarding changes in legislation to encour-
18 age or require the use (described in subsection (a)) of an
19 agency to coordinate long-term care benefits as may be
20 appropriate.

Subtitle E—Volunteer Service Credit Demonstration Projects

SEC. 3401. AMENDMENT TO THE OLDER AMERICANS ACT OF 1965.

(a) IN GENERAL.—Part B of title IV of the Older Americans Act of 1965 (42 U.S.C. 3034–3035r) is amended by adding at the end the following:

“SEC. 429K. VOLUNTEER SERVICE CREDIT DEMONSTRATION PROJECTS.

“(a) REQUIREMENTS.—The Commissioner shall—

“(1) establish and operate (directly, or through the State agency on aging or one or more area agencies on aging) a volunteer service credit demonstration project in all or part of each State;

“(2) establish criteria for selecting individuals to whom volunteer services will be provided under volunteer service credit demonstration projects operated under paragraph (1);

“(3) recruit and train (directly or through State agencies on aging or area agencies on aging) individuals who volunteer to provide services through such projects;

“(4) establish a minimum standard for each service to be provided by volunteers through such projects;

“(5) monitor services provided by volunteers through such projects to ensure that standards established under paragraph (4) are met; and

“(6) maintain (directly or through State agencies on aging or area agencies on aging) with respect to each individual who provides services through a volunteer service credit demonstration project operated under paragraph (1) a separately identifiable account showing the number of hours such individual provided such services.

“(b) DEFINITION.—For purposes of subsection (a), the term ‘volunteer service credit demonstration project’ means a demonstration project through which homemaker services, respite care for families, adult day care, and educational, transportation, and home-delivery services are provided by—

“(1) volunteer older individuals for the benefit of older individuals or low-income children; or

“(2) volunteer individuals of any age for the benefit of older individuals;

in return for the receipt of similar services under any such demonstration project (that is established under this section) at a time at which such volunteers are older individuals in need of such services.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect October 1, 1995.

○

(b) Every person who is a member of the committee shall be

subject to the provisions of the act of October 1, 1902

but; and one (4) appointed when he is

and shall be subject to the provisions of the act

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